

AMENDED IN ASSEMBLY SEPTEMBER 11, 2013

AMENDED IN ASSEMBLY SEPTEMBER 6, 2013

AMENDED IN ASSEMBLY AUGUST 27, 2013

AMENDED IN ASSEMBLY AUGUST 14, 2013

AMENDED IN SENATE APRIL 17, 2013

## SENATE BILL

**No. 239**

---

---

**Introduced by Senators Hernandez and Steinberg**

February 12, 2013

---

---

An act to amend Sections 14164, 14165, and 14167.35 of, to add ~~Section Sections 14165.58 and 14167.37 to, to add Article 5.231 (commencing with Section 14169.81) to,~~ and to add and repeal Article 5.230 (commencing with Section ~~14169.51~~) and Article ~~5.231 (commencing with Section 14169.71) of 14169.50~~) of, Chapter 7 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to Medi-Cal, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

### LEGISLATIVE COUNSEL'S DIGEST

SB 239, as amended, Hernandez. Medi-Cal: hospitals: quality assurance ~~fee. fees: distinct part skilled nursing facilities.~~

(1) Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law, subject to federal approval, imposes a quality assurance fee, as specified, on certain general acute care hospitals from July 1, 2011, through December 31, 2013. Existing

law, subject to federal approval, requires the fee to be deposited into the Hospital Quality Assurance Revenue Fund, and requires that the moneys in the fund be used, upon appropriation by the Legislature, only for certain purposes, including, among other things, paying for health care coverage for children and making supplemental payments for certain services to private hospitals, increased capitation payments to Medi-Cal managed care plans, and increased payments to mental health plans.

This bill would, subject to federal approval, impose a hospital quality assurance fee, as specified, on certain general acute care hospitals ~~from January 1, 2014, through December 31, 2015,~~ to be deposited into the Hospital Quality Assurance Revenue Fund. This bill would, subject to federal approval, provide that moneys in the Hospital Quality Assurance Revenue Fund shall be continuously appropriated *during the first program period of January 1, 2014, to December 31, 2016, inclusive,* and available only for certain purposes, including paying for health care coverage for children, as specified, and making supplemental payments for certain services to private hospitals and increased capitation payments to Medi-Cal managed care plans. The bill would also require the payment of direct grants to designated and nondesignated public hospitals in support of health care expenditures funded by the quality assurance fee *for the first program period. The bill would, for subsequent program periods, authorize the payment of direct grants for designated and nondesignated public hospitals and require that the moneys in the Hospital Quality Assurance Revenue Fund be used for the above-described purposes upon appropriation by the Legislature in the annual Budget Act.* The bill would require the department to make available all public documentation it uses to administer and audit these provisions. The bill would require the department to post specified documents on its Internet Web site relating to these provisions.

~~The bill would provide that if quality assurance fee payments are remitted to the department after the date determined by the department to be the final date for calculating the final supplemental payments, the fee payments shall be retained in the fund for purposes of funding supplemental payments supported by a hospital quality assurance fee program under subsequent legislation, but if supplemental payments are not implemented under subsequent legislation, then those quality assurance fee payments shall be returned to the private hospitals pro rata, as specified. The bill would also provide that if amounts of the quality assurance fees are collected in excess of the funds required to~~

~~make the payments above and federal rules prohibit the department from refunding the fee payments to the general acute care hospitals, the excess funds shall be returned to the private hospitals pro rata, as specified. The bill would make other conforming changes.~~

(2) Existing law provides that any county, other political subdivision of the state, or governmental entity in the state may elect to transfer funds in the form of cash or loans to the department in support of the Medi-Cal program. Existing law provides the department discretion to accept or not accept any elective transfer from a county, political subdivision, or other governmental entity for purposes of obtaining federal financial participation.

This bill would authorize the Director of Health Care Services to maximize federal financial participation to provide access to services provided by hospitals that are not reimbursed by certified public expenditure, as specified, by authorizing the use of intergovernmental transfers to fund the nonfederal share of supplemental payments as permitted under federal law.

(3) Existing law requires that the California Medical Assistance Commission be dissolved after June 30, 2012, and requires that, upon dissolution of the commission, all powers, duties, and responsibilities of the commission be transferred to the Director of Health Care Services. Existing law provides that upon a determination by the director that a payment system based on diagnosis-related groups, as described, has been developed and implemented, the powers, duties, and responsibilities conferred on the commission and transferred to the director shall no longer be exercised, except as specified.

This bill would add to those exceptions by authorizing the director to continue to administer and distribute payments for the Construction and Renovation Reimbursement Program, which provides supplemental reimbursement to hospitals that contract under the selective provider contracting program or with a county organized health system, as specified. The bill would provide that maintaining or negotiating a selective provider contract or a contract with a county organized health system shall cease to be a requirement for a hospital's participation in the Construction and Renovation Reimbursement Program.

*(4) Existing law requires, except as otherwise provided, Medi-Cal provider payments to be reduced by 1% or 5%, and provider payments for specified non-Medi-Cal programs to be reduced by 1%, for dates of service on and after March 1, 2009, and until June 1, 2011. Existing law requires, except as otherwise provided, Medi-Cal provider payments*

and payments for specified non-Medi-Cal programs to be reduced by 10% for dates of service on and after June 1, 2011.

This bill would require that reimbursement for services provided by skilled nursing facilities that are distinct parts of a general acute care hospitals be determined, for dates of service on or after October 1, 2013, without application of the reductions and limitations set forth in those provisions. The bill would also require the department to develop, in consultation with the hospital community, proposed modifications to the quality assurance fee provisions to collect additional fees for increasing managed care plan rate range increases for the purpose of increasing payments to private hospitals and nondesignated public hospitals in counties that do not have designated public hospitals. The bill would also require the department to develop a process by which a private general acute care hospital located outside the state that serves Medi-Cal beneficiaries may opt in to pay the quality assurance fee and receive supplemental payments, as specified.

(4)

(5) This bill would declare that it is to take effect immediately as an urgency statute.

Vote:  $\frac{2}{3}$ . Appropriation: yes. Fiscal committee: yes.

State-mandated local program: no.

*The people of the State of California do enact as follows:*

1     SECTION 1. Section 14164 of the Welfare and Institutions  
2     Code is amended to read:  
3     14164. (a) In addition to the required intergovernmental  
4     transfers set forth in Section 14163, any county, other political  
5     subdivision of the state, or governmental entity in the state may  
6     elect to transfer funds, subject to subdivision (m) of Section 14163,  
7     to the department in support of the Medi-Cal program. Those  
8     transfers may consist of cash or loans to the state. The department  
9     shall have the discretion to accept or not accept any elective transfer  
10    from a county, political subdivision, or other governmental entity,  
11    as well as the discretion of whether to deposit the transfer in the  
12    Medi-Cal Inpatient Payment Adjustment Fund established pursuant  
13    to Section 14163. If the department accepts a transfer pursuant to  
14    this section, the department shall obtain federal matching funds to  
15    the full extent permitted by federal law.

(b) (1) *The director may maximize available federal financial participation to provide access to services provided by hospitals that are not reimbursed by certified public expenditure pursuant to Article 5.2 (commencing with Section 14166) by authorizing the use of intergovernmental transfers to fund the nonfederal share of supplemental payments as permitted under Section 433.51 of Title 42 of the Code of Federal Regulations or any other applicable federal Medicaid laws. The transferring entity shall certify to the department that the funds are in compliance with all federal rules and regulations. Any payments funded by intergovernmental transfers shall remain with the hospital and shall not be transferred back to any county, other political subdivision of the state, or governmental entity in the state, except for federal disallowance or withhold recovery efforts by the department. Participation in intergovernmental transfers under this subdivision is voluntary on the part of the transferring entity for purposes of all applicable federal laws.*

(2) *This subdivision shall be implemented only to the extent federal financial participation is not jeopardized.*

SEC. 2. *Section 14165 of the Welfare and Institutions Code is amended to read:*

14165. (a) There is hereby created in the Governor's office the California Medical Assistance Commission, for the purpose of contracting with health care delivery systems for the provision of health care services to recipients under the California Medical Assistance program.

(b) Notwithstanding any other provision of law, the commission created pursuant to subdivision (a) shall continue through June 30, 2012, after which, it shall be dissolved and the term of any commissioner serving at that time shall end.

(1) Upon dissolution of the commission, all powers, duties, and responsibilities of the commission shall be transferred to the Director of Health Care Services. These powers, duties, and responsibilities shall include, but are not limited to, those exercised in the operation of the selective provider contracting program pursuant to Article 2.6 (commencing with Section 14081).

(2) (A) On July 1, 2012, notwithstanding any other law, employees of the California Medical Assistance Commission as of June 30, 2012, excluding commissioners, shall transfer to the State Department of Health Care Services.

(B) Employees who transfer pursuant to subparagraph (A) shall be subject to the same conditions of employment under the department as they were under the California Medical Assistance Commission, including retention of their exempt status, until the diagnosis-related groups payment system described in Section 14105.28 replaces the contract-based payment system described in this article.

(C) (i) Notwithstanding any other law or rule, persons employed by the department who transferred to the department pursuant to subparagraph (A) shall be eligible to apply for civil service examinations. Persons receiving passing scores shall have their names placed on lists resulting from these examinations, or otherwise gain eligibility for appointment. In evaluating minimum qualifications, related California Medical Assistance Commission experience shall be considered state civil service experience in a class deemed comparable by the State Personnel Board, based on the duties and responsibilities assigned.

(ii) On the date the diagnosis-related groups payment system described in Section 14105.28 replaces the contract-based system described in this article, employees who transferred to the department pursuant to subparagraph (A) shall transfer to civil service classifications within the department for which they are eligible.

(3) Upon a determination by the Director of Health Care Services that a payment system based on diagnosis-related groups as described in Section 14105.28 that is sufficient to replace the contract-based payment system described in this article has been developed and implemented, the powers, duties, and responsibilities conferred on the commission and transferred to the Director of Health Care Services shall no longer be exercised, excluding ~~both~~ *all* of the following:

(A) Stabilization payments made or committed from Sections 14166.14 and 14166.19 for services rendered prior to the director's determination pursuant to this paragraph.

(B) The ability to negotiate and make payments from the Private Hospital Supplemental Fund, established pursuant to Section 14166.12, and the Nondesignated Public Hospital Supplemental Fund, established pursuant to Section 14166.17.

(C) *The ability to continue to administer and distribute payments for the Construction and Renovation Reimbursement Program, in*

1 *accordance with Sections 14085 to 14085.57, inclusive.*  
2 *Notwithstanding any other law, maintaining or negotiating a*  
3 *selective provider contract pursuant to Article 2.6 (commencing*  
4 *with Section 14081) or a contract with a county organized health*  
5 *system shall cease to be a requirement for a hospital's participation*  
6 *in the Construction and Renovation Reimbursement Program.*

7 (4) Protections afforded to the negotiations and contracts of the  
8 commission by the California Public Records Act (Chapter 3.5  
9 (commencing with Section 6250) of Division 7 of Title 1 of the  
10 Government Code) shall be applicable to the negotiations and  
11 contracts conducted or entered into pursuant to this section by the  
12 State Department of Health Care Services.

13 (c) Notwithstanding the rulemaking provisions of Chapter 3.5  
14 (commencing with Section 11340) of Part 1 of Division 3 of Title  
15 2 of the Government Code, or any other provision of law, the State  
16 Department of Health Care Services may implement and administer  
17 this section by means of provider bulletins or other similar  
18 instructions, without taking regulatory action. The authority to  
19 implement this section as set forth in this subdivision shall include  
20 the authority to give notice by provider bulletin or other similar  
21 instruction of a determination made pursuant to paragraph (3) of  
22 subdivision (b) and to modify or supersede existing regulations in  
23 Title 22 of the California Code of Regulations that conflict with  
24 implementation of this section.

25 *SEC. 3. Section 14165.58 is added to the Welfare and*  
26 *Institutions Code, to read:*

27 *14165.58. (a) The department shall design and implement, in*  
28 *consultation with nondesignated public hospitals, an*  
29 *intergovernmental transfer program relating to Medi-Cal managed*  
30 *care services provided by nondesignated public hospitals in order*  
31 *to increase capitation payments for the purpose of increasing their*  
32 *reimbursement.*

33 *(b) The increased capitation payments under this section shall*  
34 *be actuarially equivalent to the increased fee-for-service payments*  
35 *made pursuant to Section 14165.57 to the extent permissible under*  
36 *federal law.*

37 *(c) This section shall be implemented on the later of January*  
38 *1, 2014, or the date on which all necessary federal approvals have*  
39 *been received, and only to the extent intergovernmental transfers*  
40 *from nondesignated public hospitals are provided for this purpose.*

1     (d) *Participation in the intergovernmental transfers under this*  
2     *section is voluntary on the part of the transferring entities for the*  
3     *purposes of all applicable federal laws.*

4     (e) *This section shall be implemented only to the extent federal*  
5     *financial participation is available for the reimbursement specified*  
6     *in subdivision (b).*

7     (f) *This section shall be implemented only to the extent federal*  
8     *financial participation is not jeopardized.*

9     (g) *To the extent that the director determines that the payments*  
10    *do not comply with the federal Medicaid requirements, the director*  
11    *retains the discretion not to implement an intergovernmental*  
12    *transfer and may adjust the payment as necessary to comply with*  
13    *federal Medicaid requirements.*

14    (h) *To the extent federal approval is secured, the increased*  
15    *capitation payments under this section may cover dates of service*  
16    *on or after January 1, 2014.*

17    (i) *Notwithstanding Chapter 3.5 (commencing with Section*  
18    *11340) of Part 1 of Division 3 of Title 2 of the Government Code,*  
19    *the department shall implement this section by means of policy*  
20    *letters or similar instructions, without taking further regulatory*  
21    *action. Notwithstanding Section 10231.5 of the Government code,*  
22    *the department shall provide the Joint Legislative Budget*  
23    *Committee and the fiscal and appropriate policy committees of*  
24    *the Legislature a status update of the implementation of this section*  
25    *on January 1, 2014, and annually thereafter.*

26    SEC. 4. *Section 14167.35 of the Welfare and Institutions Code*  
27    *is amended to read:*

28    14167.35. (a) *The Hospital Quality Assurance Revenue Fund*  
29    *is hereby created in the State Treasury.*

30    (b) (1) *All fees required to be paid to the state pursuant to this*  
31    *article shall be paid in the form of remittances payable to the*  
32    *department.*

33    (2) *The department shall directly transmit the fee payments to*  
34    *the Treasurer to be deposited in the Hospital Quality Assurance*  
35    *Revenue Fund. Notwithstanding Section 16305.7 of the*  
36    *Government Code, any interest and dividends earned on deposits*  
37    *in the fund shall be retained in the fund for purposes specified in*  
38    *subdivision (c).*

39    (c) *All funds in the Hospital Quality Assurance Revenue Fund,*  
40    *together with any interest and dividends earned on money in the*



1 fund, shall, upon appropriation by the Legislature, be used  
2 exclusively to enhance federal financial participation for hospital  
3 services under the Medi-Cal program, to provide additional  
4 reimbursement to, and to support quality improvement efforts of,  
5 hospitals, and to minimize uncompensated care provided by  
6 hospitals to uninsured patients, in the following order of priority:

7 (1) To pay for the department's staffing and administrative costs  
8 directly attributable to implementing Article 5.21 (commencing  
9 with Section 14167.1) and this article, including any administrative  
10 fees that the director determines shall be paid to mental health  
11 plans pursuant to subdivision (d) of Section 14167.11 and  
12 repayment of the loan made to the department from the Private  
13 Hospital Supplemental Fund pursuant to the act that added this  
14 section.

15 (2) To pay for the health care coverage for children in the  
16 amount of eighty million dollars (\$80,000,000) for each subject  
17 fiscal quarter for which payments are made under Article 5.21  
18 (commencing with Section 14167.1).

19 (3) To make increased capitation payments to managed health  
20 care plans pursuant to Article 5.21 (commencing with Section  
21 14167.1).

22 (4) To pay funds from the Hospital Quality Assurance Revenue  
23 Fund pursuant to Section 14167.5 that would have been used for  
24 grant payments and that are retained by the state, and to make  
25 increased payments to hospitals, including grants, pursuant to  
26 Article 5.21 (commencing with Section 14167.1), both of which  
27 shall be of equal priority.

28 (5) To make increased payments to mental health plans pursuant  
29 to Article 5.21 (commencing with Section 14167.1).

30 (d) Any amounts of the quality assurance fee collected in excess  
31 of the funds required to implement subdivision (c), including any  
32 funds recovered under subdivision (d) of Section 14167.14 or  
33 subdivision (e) of Section 14167.36, shall be refunded to general  
34 acute care hospitals, pro rata with the amount of quality assurance  
35 fee paid by the hospital, subject to the limitations of federal law.  
36 If federal rules prohibit the refund described in this subdivision,  
37 the excess funds shall be deposited in the Distressed Hospital Fund  
38 to be used for the purposes described in Section 14166.23, and  
39 shall be supplemental to and not supplant existing funds.

(e) Any methodology or other provision specified in Article 5.21 (commencing with Section 14167.1) and this article may be modified by the department, in consultation with the hospital community, to the extent necessary to meet the requirements of federal law or regulations to obtain federal approval or to enhance the probability that federal approval can be obtained, provided the modifications do not violate the spirit and intent of Article 5.21 (commencing with Section 14167.1) or this article and are not inconsistent with the conditions of implementation set forth in Section 14167.36.

(f) The department, in consultation with the hospital community, shall make adjustments, as necessary, to the amounts calculated pursuant to Section 14167.32 in order to ensure compliance with the federal requirements set forth in Section 433.68 of Title 42 of the Code of Federal Regulations or elsewhere in federal law.

(g) The department shall request approval from the federal Centers for Medicare and Medicaid Services for the implementation of this article. In making this request, the department shall seek specific approval from the federal Centers for Medicare and Medicaid Services to exempt providers identified in this article as exempt from the fees specified, including the submission, as may be necessary, of a request for waiver of the broad based requirement, waiver of the uniform fee requirement, or both, pursuant to paragraphs (e)(1) and (e)(2) of Section 433.68 of Title 42 of the Code of Federal Regulations.

(h) (1) For purposes of this section, a modification pursuant to this section shall be implemented only if the modification, change, or adjustment does not do either of the following:

(A) Reduces or increases the supplemental payments or grants made under Article 5.21 (commencing with Section 14167.1) in the aggregate for the 2008–09, 2009–10, and 2010–11 federal fiscal years to a hospital by more than 2 percent of the amount that would be determined under this article without any change or adjustment.

(B) Reduces or increases the amount of the fee payable by a hospital in total under this article for the 2008–09, 2009–10, and 2010–11 federal fiscal years by more than 2 percent of the amount that would be determined under this article without any change or adjustment.

(2) The department shall provide the Joint Legislative Budget Committee and the fiscal and appropriate policy committees of the Legislature a status update of the implementation of Article 5.21 (commencing with Section 14167.1) and this article on January 1, 2010, and quarterly thereafter. Information on any adjustments or modifications to the provisions of this article or Article 5.21 (commencing with Section 14167.1) that may be required for federal approval shall be provided coincident with the consultation required under subdivisions (f) and (g).

(i) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this article or Article 5.21 (commencing with Section 14167.1) by means of provider bulletins, all plan letters, or other similar instruction, without taking regulatory action. The department shall also provide notification to the Joint Legislative Budget Committee and to the appropriate policy and fiscal committees of the Legislature within five working days when the above-described action is taken in order to inform the Legislature that the action is being implemented.

(j) Notwithstanding any law, the Controller may use the funds in the Hospital Quality Assurance Revenue Fund for cashflow loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code.

(k) Notwithstanding Sections 14167.17 and 14167.40, subdivisions (b) to (h), inclusive, shall become inoperative on January 1, 2013, subdivisions (a), (i), and (j) shall remain operative until January 1, ~~2015~~, 2018, and as of January 1, ~~2015~~, 2018, this section is repealed.

*SEC. 5. Section 14167.37 is added to the Welfare and Institutions Code, to read:*

*14167.37. (a) (1) The department shall make available all public documentation it uses to administer and audit the program authorized under Article 5.230 (commencing with Section 14169.50) pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).*

*(2) In addition, upon request from a hospital, the department shall require Medi-Cal managed care plans to furnish hospitals with the amounts the plan intends to pay to the hospital pursuant to Article 5.230 (commencing with Section 14169.50). Nothing in*

1 *this paragraph shall require the department to reconcile payments*  
2 *made to individual hospitals from Medi-Cal managed care plans.*

3 *(b) Notwithstanding subdivision (a), the department shall post*  
4 *all of the following on the department's Internet Web site:*

5 *(1) Within 10 business days after receipt of approval of the*  
6 *hospital quality assurance fee program under Article 5.230*  
7 *(commencing with Section 14169.50) from the federal Centers for*  
8 *Medicare and Medicaid Services (CMS), the hospital quality*  
9 *assurance fee final model and upper payment limit calculations.*

10 *(2) Quarterly updates on payments, fee schedules, and model*  
11 *updates when applicable.*

12 *(3) Within 10 business days after receipt, information on*  
13 *managed care rate approvals.*

14 *(c) For purposes of this section, the following definitions shall*  
15 *apply:*

16 *(1) "Fee schedules" mean the dates on which the hospital*  
17 *quality assurance fee will be due from the hospitals and the dates*  
18 *on which the department will submit fee-for-service payments to*  
19 *the hospitals. "Fee schedules" also include the dates on which*  
20 *the department is expected to submit payments to managed care*  
21 *plans.*

22 *(2) "Hospital quality assurance fee final model" means the*  
23 *spreadsheet calculating the supplemental amounts based on the*  
24 *upper payment limit calculation from claims and hospital data*  
25 *sources of days and hospital services once CMS approves the*  
26 *program under Article 5.230 (commencing with Section 14169.50).*

27 *(3) "Upper payment limit calculation" means the determination*  
28 *of the federal upper payment limit on the amount of the Medicaid*  
29 *payment for which federal financial participation is available for*  
30 *a class of service and a class of health care providers, as specified*  
31 *in Part 447 of Title 42 of the Code of Federal Regulations, and*  
32 *that has been approved by CMS.*

33 *SEC. 6. Article 5.230 (commencing with Section 14169.50) is*  
34 *added to Chapter 7 of Part 3 of Division 9 of the Welfare and*  
35 *Institutions Code, to read:*

1     *Article 5.230. Medi-Cal Hospital Reimbursement Improvement*  
2                     *Act of 2013*

3  
4     14169.50. *The Legislature finds and declares all of the*  
5 *following:*

6     (a) *The Legislature continues to recognize the essential role*  
7 *that hospitals play in serving the state's Medi-Cal beneficiaries.*  
8 *To that end, it has been, and remains, the intent of the Legislature*  
9 *to improve funding for hospitals and obtain all available federal*  
10 *funds to make supplemental Medi-Cal payments to hospitals.*

11    (b) *It is the intent of the Legislature that funding provided to*  
12 *hospitals through a hospital quality assurance fee be continued*  
13 *with the goal of increasing access to care and improving hospital*  
14 *reimbursement through supplemental Medi-Cal payments to*  
15 *hospitals.*

16    (c) *It is the intent of the Legislature to recognize the fundamental*  
17 *structure of the components used to develop a successful hospital*  
18 *quality assurance fee program.*

19    (d) *It is the intent of the Legislature to impose a quality*  
20 *assurance fee to be paid by hospitals, which would be used to*  
21 *increase federal financial participation in order to make*  
22 *supplemental Medi-Cal payments to hospitals, and to help pay for*  
23 *health care coverage for low-income children.*

24    (e) *The State Department of Health Care Services shall make*  
25 *every effort to obtain the necessary federal approvals to implement*  
26 *the quality assurance fee described in subdivision (d) in order to*  
27 *make supplemental Medi-Cal payments to hospitals.*

28    (f) *It is the intent of the Legislature that the quality assurance*  
29 *fee be implemented only if all of the following conditions are met:*

30     (1) *The quality assurance fee is established in consultation with*  
31 *the hospital community.*

32     (2) *The quality assurance fee, including any interest earned*  
33 *after collection by the department, is deposited into segregated*  
34 *funds apart from the General Fund and used exclusively for*  
35 *supplemental Medi-Cal payments to hospitals, direct grants to*  
36 *public hospitals, health care coverage for low-income children,*  
37 *and for the department's direct costs of administering the program.*

38     (3) *No hospital shall be required to pay the quality assurance*  
39 *fee to the department unless and until the state receives and*

1 maintains federal approval of the quality assurance fee and related  
2 supplemental payments to hospitals.

3 (4) The full amount of the quality assurance fee assessed and  
4 collected remains available only for the purposes specified by the  
5 Legislature in this article.

6 14169.51. For purposes of this article, the following definitions  
7 shall apply:

8 (a) “Acute psychiatric days” means the total number of  
9 Medi-Cal specialty mental health service administrative days,  
10 Medi-Cal specialty mental health service acute care days, acute  
11 psychiatric administrative days, and acute psychiatric acute days  
12 identified in the Final Medi-Cal Utilization Statistics for the state  
13 fiscal year preceding the rebase calculation year as calculated by  
14 the department as of the retrieval date.

15 (b) “Acute psychiatric per diem supplemental rate” means a  
16 fixed per diem supplemental payment for acute psychiatric days.

17 (c) “Annual fee-for-service days” means the number of  
18 fee-for-service days of each hospital subject to the quality  
19 assurance fee, as reported on the days data source.

20 (d) “Annual managed care days” means the number of managed  
21 care days of each hospital subject to the quality assurance fee, as  
22 reported on the days data source.

23 (e) “Annual Medi-Cal days” means the number of Medi-Cal  
24 days of each hospital subject to the quality assurance fee, as  
25 reported on the days data source.

26 (f) “Base calendar year” means a calendar year that ends before  
27 a subject fiscal year begins, but no more than six years before a  
28 subject fiscal year begins. Beginning with the third program period,  
29 the department shall establish the base calendar year during the  
30 rebase calculation year as the calendar year for which the most  
31 recent data is available that the department determines is reliable.

32 (g) “Converted hospital” means a private hospital that becomes  
33 a designated public hospital or a nondesignated public hospital  
34 on or after the first day of a program period.

35 (h) “Days data source” means either: (1) if a hospital’s Annual  
36 Financial Disclosure Report for its fiscal year ending in the base  
37 calendar year includes data for a full fiscal year of operation, the  
38 hospital’s Annual Financial Disclosure Report retrieved from the  
39 Office of Statewide Health Planning and Development as retrieved  
40 by the department on the retrieval date pursuant to Section

1 14169.59, for its fiscal year ending in the base calendar year; or  
2 (2) if a hospital's Annual Financial Disclosure Report for its fiscal  
3 year ending in the base calendar year includes data for more than  
4 one day, but less than a full year of operation, the department's  
5 best and reasonable estimates of the hospital's Annual Financial  
6 Disclosure Report if the hospital had operated for a full year.

7 (i) "Department" means the State Department of Health Care  
8 Services.

9 (j) "Designated public hospital" shall have the meaning given  
10 in subdivision (d) of Section 14166.1.

11 (k) "Director" means the Director of Health Care Services.

12 (l) "Exempt facility" means any of the following:

13 (1) A public hospital, which shall include either of the following:

14 (A) A hospital, as defined in paragraph (25) of subdivision (a)  
15 of Section 14105.98.

16 (B) A tax-exempt nonprofit hospital that is licensed under  
17 subdivision (a) of Section 1250 of the Health and Safety Code and  
18 operating a hospital owned by a local health care district, and is  
19 affiliated with the health care district hospital owner by means of  
20 the district's status as the nonprofit corporation's sole corporate  
21 member.

22 (2) With the exception of a hospital that is in the Charitable  
23 Research Hospital peer group, as set forth in the 1991 Hospital  
24 Peer Grouping Report published by the department, a hospital  
25 that is designated as a specialty hospital in the hospital's most  
26 recently filed Office of Statewide Health Planning and Development  
27 Hospital Annual Financial Disclosure Report, as of the first day  
28 of a program period.

29 (3) A hospital that satisfies the Medicare criteria to be a  
30 long-term care hospital.

31 (4) A small and rural hospital as specified in Section 124840  
32 of the Health and Safety Code designated as that in the hospital's  
33 most recently filed Office of Statewide Health Planning and  
34 Development Hospital Annual Financial Disclosure Report, as of  
35 the first day of a program period.

36 (m) "Federal approval" means the approval by the federal  
37 government of both the quality assurance fee established pursuant  
38 to this article and the supplemental payments to private hospitals  
39 described pursuant to this article.

1 (n) “Fee-for-service per diem quality assurance fee rate” means  
2 a fixed fee on fee-for-service days.

3 (o) “Fee-for-service days” means inpatient hospital days as  
4 reported on the days data source where the service type is reported  
5 as “acute care,” “psychiatric care,” or “rehabilitation care,”  
6 and the payer category is reported as “Medicare traditional,”  
7 “county indigent programs-traditional,” “other third  
8 parties-traditional,” “other indigent,” or “other payers,” for  
9 purposes of the Annual Financial Disclosure Report submitted by  
10 hospitals to the Office of Statewide Health Planning and  
11 Development.

12 (p) “General acute care days” means the total number of  
13 Medi-Cal general acute care days, including well baby days, less  
14 any acute psychiatric inpatient days, paid by the department to a  
15 hospital for services in the base calendar year, as reflected in the  
16 state paid claims file on the retrieval date.

17 (q) “General acute care hospital” means any hospital licensed  
18 pursuant to subdivision (a) of Section 1250 of the Health and Safety  
19 Code.

20 (r) “General acute care per diem supplemental rate” means a  
21 fixed per diem supplemental payment for general acute care days.

22 (s) “High acuity days” means Medi-Cal coronary care unit  
23 days, pediatric intensive care unit days, intensive care unit days,  
24 neonatal intensive care unit days, and burn unit days paid by the  
25 department to a hospital for services in the base calendar year,  
26 as reflected in the state paid claims file prepared by the department  
27 on the retrieval date.

28 (t) “High acuity per diem supplemental rate” means a fixed per  
29 diem supplemental payment for high acuity days for specified  
30 hospitals in Section 14169.55.

31 (u) “High acuity trauma per diem supplemental rate” means a  
32 fixed per diem supplemental payment for high acuity days for  
33 specified hospitals in Section 14169.55 that have been designated  
34 as specified types of trauma hospitals.

35 (v) “Hospital community” includes, but is not limited to, the  
36 statewide hospital industry organization and systems representing  
37 general acute care hospitals.

38 (w) “Hospital inpatient services” means all services covered  
39 under Medi-Cal and furnished by hospitals to patients who are  
40 admitted as hospital inpatients and reimbursed on a fee-for-service



1 basis by the department directly or through its fiscal intermediary.  
2 Hospital inpatient services include outpatient services furnished  
3 by a hospital to a patient who is admitted to that hospital within  
4 24 hours of the provision of the outpatient services that are related  
5 to the condition for which the patient is admitted. Hospital inpatient  
6 services do not include services for which a managed health care  
7 plan is financially responsible.

8 (x) “Hospital outpatient services” means all services covered  
9 under Medi-Cal furnished by hospitals to patients who are  
10 registered as hospital outpatients and reimbursed by the  
11 department on a fee-for-service basis directly or through its fiscal  
12 intermediary. Hospital outpatient services do not include services  
13 for which a managed health care plan is financially responsible,  
14 or services rendered by a hospital-based federally qualified health  
15 center for which reimbursement is received pursuant to Section  
16 14132.100.

17 (y) “Managed care days” means inpatient hospital days as  
18 reported on the days data source where the service type is reported  
19 as “acute care,” “psychiatric care,” or “rehabilitation care,”  
20 and the payer category is reported as “Medicare managed care,”  
21 “county indigent programs-managed care,” or “other third  
22 parties-managed care,” for purposes of the Annual Financial  
23 Disclosure Report submitted by hospitals to the Office of Statewide  
24 Health Planning and Development.

25 (z) “Managed care per diem quality assurance fee rate” means  
26 a fixed fee on managed care days.

27 (aa) (1) “Managed health care plan” means a health care  
28 delivery system that manages the provision of health care and  
29 receives prepaid capitated payments from the state in return for  
30 providing services to Medi-Cal beneficiaries.

31 (2) (A) Managed health care plans include county organized  
32 health systems and entities contracting with the department to  
33 provide or arrange services for Medi-Cal beneficiaries pursuant  
34 to the two-plan model, geographic managed care, or regional  
35 managed care for the rural expansion. Entities providing these  
36 services contract with the department pursuant to any of the  
37 following:

38 (i) Article 2.7 (commencing with Section 14087.3).

39 (ii) Article 2.8 (commencing with Section 14087.5).

40 (iii) Article 2.81 (commencing with Section 14087.96).

1 (iv) Article 2.82 (commencing with Section 14087.98).

2 (v) Article 2.91 (commencing with Section 14089).

3 (B) Managed health care plans do not include any of the  
4 following:

5 (i) Mental health plans contracting to provide mental health  
6 care for Medi-Cal beneficiaries pursuant to Chapter 8.9  
7 (commencing with Section 14700).

8 (ii) Health plans not covering inpatient services such as primary  
9 care case management plans operating pursuant to Section  
10 14088.85.

11 (iii) Program for All-Inclusive Care for the Elderly  
12 organizations operating pursuant to Chapter 8.75 (commencing  
13 with Section 14591).

14 (ab) “Medi-Cal days” means inpatient hospital days as reported  
15 on the days data source where the service type is reported as  
16 “acute care,” “psychiatric care,” or “rehabilitation care,” and  
17 the payer category is reported as “Medi-Cal traditional” or  
18 “Medi-Cal managed care,” for purposes of the Annual Financial  
19 Disclosure Report submitted by hospitals to the Office of Statewide  
20 Health Planning and Development.

21 (ac) “Medi-Cal fee-for-service days” means inpatient hospital  
22 days as reported on the days data source where the service type  
23 is reported as “acute care,” “psychiatric care,” or “rehabilitation  
24 care,” and the payer category is reported as “Medi-Cal  
25 traditional” for purposes of the Annual Financial Disclosure  
26 Report submitted by hospitals to the Office of Statewide Health  
27 Planning and Development.

28 (ad) “Medi-Cal managed care days” means the total number  
29 of general acute care days, including well baby days, listed for  
30 the county organized health system and prepaid health plans  
31 identified in the Final Medi-Cal Utilization Statistics for the state  
32 fiscal year preceding the rebase calculation year, as calculated  
33 by the department as of the retrieval date.

34 (ae) “Medi-Cal managed care fee days” means inpatient  
35 hospital days as reported on the days data source where the service  
36 type is reported as “acute care,” “psychiatric care,” or  
37 “rehabilitation care,” and the payer category is reported as  
38 “Medi-Cal managed care” for purposes of the Annual Financial  
39 Disclosure Report submitted by hospitals to the Office of Statewide  
40 Health Planning and Development.

1     ~~(af) “Medi-Cal per diem quality assurance fee rate” means a~~  
2     ~~fixed fee on Medi-Cal days.~~

3     ~~(ag) “Medicaid inpatient utilization rate” means Medicaid~~  
4     ~~inpatient utilization rate as defined in Section 1396r-4 of Title 42~~  
5     ~~of the United States Code and as set forth in the Final Medi-Cal~~  
6     ~~Utilization Statistics for the state fiscal year preceding the rebase~~  
7     ~~calculation year, as calculated by the department as of the retrieval~~  
8     ~~date.~~

9     ~~(ah) “New hospital” means a hospital operation, business, or~~  
10    ~~facility functioning under current or prior ownership as a private~~  
11    ~~hospital that does not have a days data source or a hospital that~~  
12    ~~has a days data source in whole, or in part, from a previous~~  
13    ~~operator where there is an outstanding monetary obligation owed~~  
14    ~~to the state in connection with the Medi-Cal program and the~~  
15    ~~hospital is not, or does not agree to become, financially responsible~~  
16    ~~to the department for the outstanding monetary obligation in~~  
17    ~~accordance with subdivision (d) of Section 14169.61.~~

18    ~~(ai) “Nondesignated public hospital” means either of the~~  
19    ~~following:~~

20    ~~(1) A public hospital that is licensed under subdivision (a) of~~  
21    ~~Section 1250 of the Health and Safety Code, is not designated as~~  
22    ~~a specialty hospital in the hospital’s most recently filed Annual~~  
23    ~~Financial Disclosure Report, as of the first day of a program~~  
24    ~~period, and satisfies the definition in paragraph (25) of subdivision~~  
25    ~~(a) of Section 14105.98, excluding designated public hospitals.~~

26    ~~(2) A tax-exempt nonprofit hospital that is licensed under~~  
27    ~~subdivision (a) of Section 1250 of the Health and Safety Code, is~~  
28    ~~not designated as a specialty hospital in the hospital’s most~~  
29    ~~recently filed Annual Financial Disclosure Report, as of the first~~  
30    ~~day of a program period, is operating a hospital owned by a local~~  
31    ~~health care district, and is affiliated with the health care district~~  
32    ~~hospital owner by means of the district’s status as the nonprofit~~  
33    ~~corporation’s sole corporate member.~~

34    ~~(aj) “Outpatient base amount” means the total amount of~~  
35    ~~payments for hospital outpatient services made to a hospital in~~  
36    ~~the base calendar year, as reflected in the state paid claims files~~  
37    ~~prepared by the department as of the retrieval date.~~

38    ~~(ak) “Outpatient supplemental rate” means a fixed proportional~~  
39    ~~supplemental payment for Medi-Cal outpatient services.~~

1     (al) “Prepaid health plan hospital” means a hospital owned by  
2     a nonprofit public benefit corporation that shares a common board  
3     of directors with a nonprofit health care service plan, which  
4     exclusively contracts with no more than two medical groups in the  
5     state to provide or arrange for professional medical services for  
6     the enrollees of the plan, as of the effective date of this article.

7     (am) “Prepaid health plan hospital managed care per diem  
8     quality assurance fee rate” means a fixed fee on non-Medi-Cal  
9     managed care fee days for prepaid health plan hospitals.

10    (an) “Prepaid health plan hospital Medi-Cal managed care per  
11    diem quality assurance fee rate” means a fixed fee on Medi-Cal  
12    managed care fee days for prepaid health plan hospitals.

13    (ao) “Private hospital” means a hospital that meets all of the  
14    following conditions:

15    (1) Is licensed pursuant to subdivision (a) of Section 1250 of  
16    the Health and Safety Code.

17    (2) Is in the Charitable Research Hospital peer group, as set  
18    forth in the 1991 Hospital Peer Grouping Report published by the  
19    department, or is not designated as a specialty hospital in the  
20    hospital’s most recently filed Office of Statewide Health Planning  
21    and Development Annual Financial Disclosure Report, as of the  
22    first day of a program period.

23    (3) Does not satisfy the Medicare criteria to be classified as a  
24    long-term care hospital.

25    (4) Is a nonpublic hospital, nonpublic converted hospital, or  
26    converted hospital as those terms are defined in paragraphs (26)  
27    to (28), inclusive, respectively, of subdivision (a) of Section  
28    14105.98.

29    (5) Is not a nondesignated public hospital or a designated public  
30    hospital.

31    (ap) “Program period” means a period not to exceed three  
32    years during which a fee model and a supplemental payment model  
33    developed under this article shall be effective. The first program  
34    period shall be the period beginning January 1, 2014, and ending  
35    December 31, 2016, inclusive. The second program period shall  
36    be the period beginning on January 1, 2017, and ending June 30,  
37    2019. Each subsequent program period shall begin on the day  
38    immediately following the last day of the immediately preceding  
39    program period and shall end on the last day of a state fiscal year,  
40    as determined by the department.

1     (aq) “Quality assurance fee” means the quality assurance fee  
2 assessed pursuant to Section 14169.52 and collected on the basis  
3 of the quarterly quality assurance fee.

4     (ar) (1) “Quarterly quality assurance fee” means, with respect  
5 to a hospital that is not a prepaid health plan hospital, the sum of  
6 all of the following:

7         (A) The annual fee-for-service days for an individual hospital  
8 multiplied by the fee-for-service per diem quality assurance fee  
9 rate, divided by four.

10        (B) The annual managed care days for an individual hospital  
11 multiplied by the managed care per diem quality assurance fee  
12 rate, divided by four.

13        (C) The annual Medi-Cal days for an individual hospital  
14 multiplied by the Medi-Cal per diem quality assurance fee rate,  
15 divided by four.

16     (2) “Quarterly quality assurance fee” means, with respect to a  
17 hospital that is a prepaid health plan hospital, the sum of all of  
18 the following:

19         (A) The annual fee-for-service days for an individual hospital  
20 multiplied by the fee-for-service per diem quality assurance fee  
21 rate, divided by four.

22         (B) The annual managed care days for an individual hospital  
23 multiplied by the prepaid health plan hospital managed care per  
24 diem quality assurance fee rate, divided by four.

25         (C) The annual Medi-Cal managed care fee days for an  
26 individual hospital multiplied by the prepaid health plan hospital  
27 Medi-Cal managed care per diem quality assurance fee rate,  
28 divided by four.

29         (D) The annual Medi-Cal fee-for-service days for an individual  
30 hospital multiplied by the Medi-Cal per diem quality assurance  
31 fee rate, divided by four.

32     (as) “Rebase calculation year” means a state fiscal year during  
33 which the department shall rebase the data, including, but not  
34 limited to, the days data source, used for the following: acute  
35 psychiatric days, annual fee-for-service days, annual managed  
36 care days, annual Medi-Cal days, fee-for-service days, general  
37 acute care days, high acuity days, managed care days, Medi-Cal  
38 days, Medi-Cal fee-for-service days, Medi-Cal managed care days,  
39 Medi-Cal managed care fee days, outpatient base amount, and  
40 transplant days, pursuant to Section 14169.59. Beginning with the

1 *third program period, the rebase calculation year for a program*  
2 *period shall be the last subject fiscal year of the immediately*  
3 *preceding program period.*

4 *(at) “Rebase year” means the first state fiscal year of a program*  
5 *period and shall immediately follow a rebase calculation year.*

6 *(au) “Retrieval date” means a day for each data element during*  
7 *the last quarter of the rebase calculation year upon which the*  
8 *department retrieves the data, including, but not limited to, the*  
9 *days data source, used for the following: acute psychiatric days,*  
10 *annual fee-for-service days, annual managed care days, annual*  
11 *Medi-Cal days, fee-for-service days, general acute care days, high*  
12 *acuity days, managed care days, Medi-Cal days, Medi-Cal*  
13 *fee-for-service days, Medi-Cal managed care days, Medi-Cal*  
14 *managed care fee days, outpatient base amount, and transplant*  
15 *days, pursuant to Section 14169.59. The retrieval date for each*  
16 *data element may be a different date within the quarter as*  
17 *determined to be necessary and appropriate by the department.*

18 *(av) “Subacute supplemental rate” means a fixed proportional*  
19 *supplemental payment for acute inpatient services based on a*  
20 *hospital’s prior provision of Medi-Cal subacute services.*

21 *(aw) “Subject fiscal quarter” means a state fiscal quarter*  
22 *beginning on or after the first day of a program period and ending*  
23 *on or before the last day of a program period.*

24 *(ax) “Subject fiscal year” means a state fiscal year beginning*  
25 *on or after the first day of a program period and ending on or*  
26 *before the last day of a program period.*

27 *(ay) “Subject month” means a calendar month beginning on*  
28 *or after the first day of a program period and ending on or before*  
29 *the last day of a program period.*

30 *(az) “Transplant days” means the number of Medi-Cal days*  
31 *for Medicare Severity-Diagnosis Related Groups (MS-DRGs) 1,*  
32 *2, 5 to 10, inclusive, 14, 15, or 652, according to the Patient*  
33 *Discharge file from the Office of Statewide Health Planning and*  
34 *Development for the base calendar year accessed on the retrieval*  
35 *date.*

36 *(ba) “Transplant per diem supplemental rate” means a fixed*  
37 *per diem supplemental payment for transplant days.*

38 *(bb) “Upper payment limit” means a federal upper payment*  
39 *limit on the amount of the Medicaid payment for which federal*  
40 *financial participation is available for a class of service and a*

1 *class of health care providers, as specified in Part 447 of Title 42*  
2 *of the Code of Federal Regulations. The applicable upper payment*  
3 *limit shall be separately calculated for inpatient and outpatient*  
4 *hospital services.*

5 *14169.52. (a) There shall be imposed on each general acute*  
6 *care hospital that is not an exempt facility a quality assurance fee,*  
7 *except that a quality assurance fee under this article shall not be*  
8 *imposed on a converted hospital for the periods when the hospital*  
9 *is a public hospital or a new hospital with respect to a program*  
10 *period.*

11 *(b) The department shall compute the quarterly quality*  
12 *assurance fee for each subject fiscal year during a program period*  
13 *pursuant to Section 14169.59.*

14 *(c) Subject to Section 14169.63, on the later of the date of the*  
15 *department's receipt of federal approval or the first day of each*  
16 *program period, the following shall commence:*

17 *(1) Within 10 business days following receipt of the notice of*  
18 *federal approval, the department shall send notice to each hospital*  
19 *subject to the quality assurance fee, which shall contain the*  
20 *following information:*

21 *(A) The date that the state received notice of federal approval.*

22 *(B) The quarterly quality assurance fee for each subject fiscal*  
23 *year.*

24 *(C) The date on which each payment is due.*

25 *(2) The hospitals shall pay the quarterly quality assurance fee,*  
26 *based on a schedule developed by the department. The department*  
27 *shall establish the date that each payment is due, provided that*  
28 *the first payment shall be due no earlier than 20 days following*  
29 *the department sending the notice pursuant to paragraph (1), and*  
30 *the payments shall be paid at least one month apart, but if possible,*  
31 *the payments shall be paid on a quarterly basis.*

32 *(3) Notwithstanding any other provision of this section, the*  
33 *amount of each hospital's quarterly quality assurance fee for a*  
34 *program period that has not been paid by the hospital before 15*  
35 *days prior to the end of a program period shall be paid by the*  
36 *hospital no later than 15 days prior to the end of a program period.*

37 *(4) Each hospital described in subdivision (a) shall pay the*  
38 *quarterly quality assurance fees that are due, if any, in the amounts*  
39 *and at the times set forth in the notice unless superseded by a*  
40 *subsequent notice from the department.*

1 (d) The quality assurance fee, as assessed pursuant to this  
2 section, shall be paid by each hospital subject to the fee to the  
3 department for deposit in the Hospital Quality Assurance Revenue  
4 Fund. Deposits may be accepted at any time and shall be credited  
5 toward the program period for which the fees were assessed. This  
6 article shall not affect the ability of a hospital to pay fees assessed  
7 for a program period after the end of that program period.

8 (e) This section shall become inoperative if the federal Centers  
9 for Medicare and Medicaid Services denies approval for, or does  
10 not approve before December 1, 2016, the implementation of the  
11 quality assurance fee pursuant to this article or the supplemental  
12 payments to private hospitals pursuant to this article for the first  
13 program period.

14 (f) In no case shall the aggregate fees collected in a federal  
15 fiscal year pursuant to this section, former Section 14167.32,  
16 Section 14168.32, and Section 14169.32 exceed the maximum  
17 percentage of the annual aggregate net patient revenue for  
18 hospitals subject to the fee that is prescribed pursuant to federal  
19 law and regulations as necessary to preclude a finding that an  
20 indirect guarantee has been created.

21 (g) (1) Interest shall be assessed on quality assurance fees not  
22 paid on the date due at the greater of 10 percent per annum or the  
23 rate at which the department assesses interest on Medi-Cal  
24 program overpayments to hospitals that are not repaid when due.  
25 Interest shall begin to accrue the day after the date the payment  
26 was due and shall be deposited in the Hospital Quality Assurance  
27 Revenue Fund.

28 (2) In the event that any fee payment is more than 60 days  
29 overdue, a penalty equal to the interest charge described in  
30 paragraph (1) shall be assessed and due for each month for which  
31 the payment is not received after 60 days.

32 (h) When a hospital fails to pay all or part of the quality  
33 assurance fee on or before the date that payment is due, the  
34 department may immediately begin to deduct the unpaid assessment  
35 and interest from any Medi-Cal payments owed to the hospital,  
36 or, in accordance with Section 12419.5 of the Government Code,  
37 from any other state payments owed to the hospital until the full  
38 amount is recovered. All amounts, except penalties, deducted by  
39 the department under this subdivision shall be deposited in the  
40 Hospital Quality Assurance Revenue Fund. The remedy provided



1 *to the department by this section is in addition to other remedies*  
2 *available under law.*

3 *(i) The payment of the quality assurance fee shall not be*  
4 *considered as an allowable cost for Medi-Cal cost reporting and*  
5 *reimbursement purposes.*

6 *(j) The department shall work in consultation with the hospital*  
7 *community to implement this article.*

8 *(k) This subdivision creates a contractually enforceable promise*  
9 *on behalf of the state to use the proceeds of the quality assurance*  
10 *fee, including any federal matching funds, solely and exclusively*  
11 *for the purposes set forth in this article, to limit the amount of the*  
12 *proceeds of the quality assurance fee to be used to pay for the*  
13 *health care coverage of children as provided in Section 14169.53,*  
14 *to limit any payments for the department's costs of administration*  
15 *to the amounts set forth in this article, to maintain and continue*  
16 *prior reimbursement levels as set forth in Section 14169.68 on the*  
17 *effective date of that section, and to otherwise comply with all its*  
18 *obligations set forth in this article, provided that amendments that*  
19 *arise from, or have as a basis for, a decision, advice, or*  
20 *determination by the federal Centers for Medicare and Medicaid*  
21 *Services relating to federal approval of the quality assurance fee*  
22 *or the payments set forth in this article shall control for the*  
23 *purposes of this subdivision.*

24 *(l) (1) Subject to paragraph (2), the director may waive any or*  
25 *all interest and penalties assessed under this article in the event*  
26 *that the director determines, in his or her sole discretion, that the*  
27 *hospital has demonstrated that imposition of the full quality*  
28 *assurance fee on the timelines applicable under this article has a*  
29 *high likelihood of creating a financial hardship for the hospital*  
30 *or a significant danger of reducing the provision of needed health*  
31 *care services.*

32 *(2) Waiver of some or all of the interest or penalties under this*  
33 *subdivision shall be conditioned on the hospital's agreement to*  
34 *make fee payments, or to have the payments withheld from*  
35 *payments otherwise due from the Medi-Cal program to the hospital,*  
36 *on a schedule developed by the department that takes into account*  
37 *the financial situation of the hospital and the potential impact on*  
38 *services.*

39 *(3) A decision by the director under this subdivision shall not*  
40 *be subject to judicial review.*

1     (4) If fee payments are remitted to the department after the date  
2     determined by the department to be the final date for calculating  
3     the final supplemental payments for a program period under this  
4     article, the fee payments shall be refunded to general acute care  
5     hospitals, pro rata with the amount of quality assurance fee paid  
6     by the hospital in the program period, subject to the limitations  
7     of federal law. If federal rules prohibit the refund described in this  
8     paragraph, the excess funds shall be used as quality assurance  
9     fees for the next program period for general acute care hospitals,  
10    pro rata with the quality assurance fees paid by the hospital for  
11    the program period.

12    (5) If during the implementation of this article, fee payments  
13    that were due under former Article 5.21 (commencing with Section  
14    14167.1) and former Article 5.22 (commencing with Section  
15    14167.31), or former Article 5.226 (commencing with Section  
16    14168.1) and Article 5.227 (commencing with Section 14168.31),  
17    or Article 5.228 (commencing with Section 14169.1) and Article  
18    5.229 (commencing with Section 14169.31) are remitted to the  
19    department under a payment plan or for any other reason, and the  
20    final date for calculating the final supplemental payments under  
21    those articles has passed, then those fee payments shall be  
22    deposited in the fund to support the uses established by this article.

23    14169.53. (a) (1) All fees required to be paid to the state  
24    pursuant to this article shall be paid in the form of remittances  
25    payable to the department.

26    (2) The department shall directly transmit the fee payments to  
27    the Treasurer to be deposited in the Hospital Quality Assurance  
28    Revenue Fund, created pursuant to Section 14167.35.  
29    Notwithstanding Section 16305.7 of the Government Code, any  
30    interest and dividends earned on deposits in the fund from the  
31    proceeds of the fee assessed pursuant to this article shall be  
32    retained in the fund for purposes specified in subdivision (b).

33    (b) (1) Notwithstanding subdivision (c) of Section 14167.35,  
34    subdivision (b) of Section 14168.33, and subdivision (b) of Section  
35    14169.33, all funds from the proceeds of the fee assessed pursuant  
36    to this article in the Hospital Quality Assurance Revenue Fund,  
37    together with any interest and dividends earned on money in the  
38    fund, shall continue to be used exclusively to enhance federal  
39    financial participation for hospital services under the Medi-Cal  
40    program, to provide additional reimbursement to, and to support

1 *quality improvement efforts of, hospitals, and to minimize*  
2 *uncompensated care provided by hospitals to uninsured patients,*  
3 *as well as to pay for the state's administrative costs and to provide*  
4 *funding for children's health coverage, in the following order of*  
5 *priority:*

6 *(A) To pay for the department's staffing and administrative*  
7 *costs directly attributable to implementing this article, not to*  
8 *exceed two hundred fifty thousand dollars (\$250,000) for each*  
9 *subject fiscal quarter, exclusive of any federal matching funds.*

10 *(B) To pay for the health care coverage, as described in*  
11 *subdivision (g), except that for the two subject fiscal quarters in*  
12 *the 2013–14 fiscal year, the amount for children's health care*  
13 *coverage shall be one hundred fifty-five million dollars*  
14 *(\$155,000,000) for each subject fiscal quarter, exclusive of any*  
15 *federal matching funds.*

16 *(C) To make increased capitation payments to managed health*  
17 *care plans pursuant to this article and Section 14169.82, including*  
18 *the nonfederal share of capitation payments to managed health*  
19 *care plans pursuant to this article and Section 14169.82 for*  
20 *services provided to individuals who meet the eligibility*  
21 *requirements in Section 1902(a)(10)(A)(i)(VIII) of Title XIX of the*  
22 *federal Social Security Act (42 U.S.C. Sec.*  
23 *1396a(a)(10)(A)(i)(VIII)), and who meet the conditions described*  
24 *in Section 1905(y) of the federal Social Security Act (42 U.S.C.*  
25 *Sec. 1396d(y)).*

26 *(D) To make increased payments and direct grants to hospitals*  
27 *pursuant to this article and Section 14169.83, including the*  
28 *nonfederal share of payments to hospitals under this article and*  
29 *Section 14169.83 for services provided to individuals who meet*  
30 *the eligibility requirements in Section 1902(a)(10)(A)(i)(VIII) of*  
31 *Title XIX of the federal Social Security Act (42 U.S.C. Sec.*  
32 *1396a(a)(10)(A)(i)(VIII)), and who meet the conditions described*  
33 *in Section 1905(y) of the federal Social Security Act (42 U.S.C.*  
34 *Sec. 1396d(y)).*

35 *(2) Notwithstanding subdivision (c) of Section 14167.35,*  
36 *subdivision (b) of Section 14168.33, and subdivision (b) of Section*  
37 *14169.33, and notwithstanding Section 13340 of the Government*  
38 *Code, the moneys in the Hospital Quality Assurance Revenue Fund*  
39 *shall be continuously appropriated during the first program period*  
40 *only, without regard to fiscal year, for the purposes of this article,*

Article 5.229 (commencing with Section 14169.31), Article 5.228 (commencing with Section 14169.1), Article 5.227 (commencing with Section 14168.31), former Article 5.226 (commencing with Section 14168.1), former Article 5.22 (commencing with Section 14167.31), and former Article 5.21 (commencing with Section 14167.1).

(3) For subsequent program periods, the moneys in the Hospital Quality Assurance Revenue Fund shall be used, upon appropriation by the Legislature in the annual Budget Act, for the purposes of this article and Sections 14169.82 and 14169.83.

(c) Any amounts of the quality assurance fee collected in excess of the funds required to implement subdivision (b), including any funds recovered under subdivision (d) of Section 14169.61, shall be refunded to general acute care hospitals, pro rata with the amount of quality assurance fee paid by the hospital, subject to the limitations of federal law. If federal rules prohibit the refund described in this subdivision, the excess funds shall be used as quality assurance fees for the next program period for general acute care hospitals, pro rata with the amount of quality assurance fees paid by the hospital for the program period.

(d) Any methodology or other provision specified in this article may be modified by the department, in consultation with the hospital community, to the extent necessary to meet the requirements of federal law or regulations to obtain federal approval or to enhance the probability that federal approval can be obtained, provided the modifications do not violate the spirit, purposes, and intent of this article and are not inconsistent with the conditions of implementation set forth in Section 14169.72. The department shall notify the Joint Legislative Budget Committee and the fiscal and appropriate policy committees of the Legislature 30 days prior to implementation of a modification pursuant to this subdivision.

(e) The department, in consultation with the hospital community, shall make adjustments, as necessary, to the amounts calculated pursuant to Section 14169.52 in order to ensure compliance with the federal requirements set forth in Section 433.68 of Title 42 of the Code of Federal Regulations or elsewhere in federal law.

(f) The department shall request approval from the federal Centers for Medicare and Medicaid Services for the implementation of this article. In making this request, the

1 department shall seek specific approval from the federal Centers  
2 for Medicare and Medicaid Services to exempt providers identified  
3 in this article as exempt from the fees specified, including the  
4 submission, as may be necessary, of a request for waiver of the  
5 broad-based requirement, waiver of the uniform fee requirement,  
6 or both, pursuant to paragraphs (1) and (2) of subdivision (e) of  
7 Section 433.68 of Title 42 of the Code of Federal Regulations.

8 (g) (1) For purposes of this subdivision, the following  
9 definitions shall apply:

10 (A) “Actual net benefit” means the net benefit determined by  
11 the department for a net benefit period after the conclusion of the  
12 net benefit period using payments and grants actually made, and  
13 fees actually collected, for the net benefit period.

14 (B) “Aggregate fees” means the aggregate fees collected from  
15 hospitals under this article.

16 (C) “Aggregate payments” means the aggregate payments and  
17 grants made directly or indirectly to hospitals under this article,  
18 including payments and grants described in Sections 14169.54,  
19 14169.55, 14169.57, and 14169.58, and subdivision (b) of Section  
20 14169.82.

21 (D) “Fund” means the Hospital Quality Assurance Revenue  
22 Fund established pursuant to Section 14167.35.

23 (E) “Net benefit” means the aggregate payments for a net  
24 benefit period minus the aggregate fees for the net benefit period.

25 (F) “Net benefit period” means a subject fiscal year or portion  
26 thereof that is in a program period and begins on or after July 1,  
27 2014.

28 (G) “Preliminary net benefit” means the net benefit determined  
29 by the department for a net benefit period prior to the beginning  
30 of that net benefit period using estimated or projected data.

31 (2) The amount of funding provided for children’s health care  
32 coverage under subdivision (b) for a net benefit period shall be  
33 equal to 24 percent of the net benefit for that net benefit period.

34 (3) The department shall determine the preliminary net benefit  
35 for all net benefit periods in the first program period before July  
36 1, 2014. The department shall determine the preliminary net benefit  
37 for all net benefit periods in a subsequent program period before  
38 the beginning of the program period.

39 (4) The department shall determine the actual net benefit and  
40 make the reconciliation described in paragraph (5) for each net

1 *benefit period within six months after the date determined by the*  
2 *department pursuant to subdivision (h).*

3 *(5) For each net benefit period, the department shall reconcile*  
4 *the amount of moneys in the fund used for children's health*  
5 *coverage based on the preliminary net benefit with the amount of*  
6 *the fund that may be used for children's health coverage under*  
7 *this subdivision based on the actual net benefit. For each net*  
8 *benefit period, any amounts that were in the fund and used for*  
9 *children's health coverage in excess of the 24 percent of the actual*  
10 *net benefit shall be returned to the fund, and the amount, if any,*  
11 *by which 24 percent of the actual net benefit exceeds 24 percent*  
12 *of the preliminary net benefit shall be available from the fund to*  
13 *the department for children's health coverage. The department*  
14 *shall notify the Joint Legislative Budget Committee and the fiscal*  
15 *and appropriate policy committees of the Legislature of the results*  
16 *of the reconciliation for each net benefit period pursuant to this*  
17 *paragraph within five working days of performing the*  
18 *reconciliation.*

19 *(6) The department shall make all calculations and*  
20 *reconciliations required by this subdivision in consultation with*  
21 *the hospital community using data that the department determines*  
22 *is the best data reasonably available.*

23 *(h) After consultation with the hospital community, the*  
24 *department shall determine a date upon which substantially all*  
25 *fees have been paid and substantially all supplemental payments,*  
26 *grants, and rate range increases have been made for a program*  
27 *period, which date shall be no later than two years after the end*  
28 *of a program period. After the date determined by the department*  
29 *pursuant to this subdivision, no further supplemental payments*  
30 *shall be made under the program period, and any fees collected*  
31 *with respect to the program period shall be used for a subsequent*  
32 *program period consistent with this section. Nothing in this*  
33 *subdivision shall affect the department's authority to collect quality*  
34 *assurance fees for a program period after the end of the program*  
35 *period or after the date determined by the department pursuant to*  
36 *this subdivision. The department shall notify the Joint Legislative*  
37 *Budget Committee and fiscal and appropriate policy committees*  
38 *of that date within five working days of the determination.*

39 *(i) Use of the fee proceeds to enhance federal financial*  
40 *participation pursuant to subdivision (b) shall include use of the*

proceeds to supply the nonfederal share, if any, of payments to hospitals under this article for services provided to individuals who meet the eligibility requirements in Section 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)), and who meet the conditions described in Section 1905(y) of the federal Social Security Act (42 U.S.C. Sec. 1396d(y)) such that expenditures for services provided to the individual are eligible for the enhanced federal medical assistance percentage described in that section.

14169.54. (a) Private hospitals shall be paid supplemental amounts for each subject fiscal quarter in a program period for the provision of hospital outpatient services as set forth in this section. The supplemental amounts shall be in addition to any other amounts payable to hospitals with respect to those services and shall not affect any other payments to hospitals. The supplemental amounts shall result in payments equal to the statewide aggregate upper payment limit for private hospitals for each subject fiscal year.

(b) Except as set forth in subdivisions (d) and (e), each private hospital shall be paid an amount for each subject fiscal year equal to the outpatient supplemental rate multiplied by the hospital's outpatient base amount, which payments shall be made on a quarterly basis. The outpatient supplemental rate shall result in payments to hospitals that equal the applicable federal upper payment limit for the subject fiscal year, except that with respect to a subject fiscal year that begins before the start of a program period or that ends after the end of the program period for which the payments are made, the outpatient supplemental rate shall result in payments to hospitals that equal a percentage of the applicable upper payment limit where the percentage equals the percentage of the subject fiscal year that occurs during the program period. For purposes of this subdivision, the applicable federal upper payment limit shall be the federal upper payment limit for hospital outpatient services furnished by private hospitals for each subject fiscal year.

(c) In the event federal financial participation for a subject fiscal year is not available for all of the supplemental amounts payable to private hospitals under subdivision (b) due to the application of an upper payment limit or for any other reason, both of the following shall apply:

1     (1) *The total amount payable to private hospitals under*  
2     *subdivision (b) for the subject fiscal year shall be reduced to the*  
3     *amount for which federal financial participation is available.*

4     (2) *The amount payable under subdivision (b) to each private*  
5     *hospital for the subject fiscal year shall be equal to the amount*  
6     *computed under subdivision (b) multiplied by the ratio of the total*  
7     *amount for which federal financial participation is available to*  
8     *the total amount computed under subdivision (b).*

9     (d) *Payments shall not be made under this section for the periods*  
10    *when a hospital is a new hospital during a program period.*

11    (e) *Payments shall be made to a converted hospital that converts*  
12    *during a subject fiscal quarter by multiplying the hospital's*  
13    *outpatient supplemental payment as calculated in subdivision (b)*  
14    *by the number of days that the hospital was a private hospital in*  
15    *the subject fiscal quarter, divided by the number of days in the*  
16    *subject fiscal quarter. Payments shall not be made to a converted*  
17    *hospital in any subsequent subject fiscal quarter.*

18    14169.55. (a) *Private hospitals shall be paid supplemental*  
19    *amounts for the provision of hospital inpatient services for each*  
20    *subject fiscal quarter in a program period as set forth in this*  
21    *section. The supplemental amounts shall be in addition to any*  
22    *other amounts payable to hospitals with respect to those services*  
23    *and shall not affect any other payments to hospitals. The inpatient*  
24    *supplemental amounts shall result in payments to hospitals that*  
25    *equal the applicable federal upper payment limit for the subject*  
26    *fiscal year, except that with respect to a subject fiscal year that*  
27    *begins before the start of a program period or that ends after the*  
28    *end of the program period for which the payments are made, the*  
29    *inpatient supplemental amounts shall result in payments to*  
30    *hospitals that equal a percentage of the applicable upper payment*  
31    *limit where the percentage equals the percentage of the subject*  
32    *fiscal year that occurs during the program period.*

33    (b) *Except as set forth in subdivisions (e) and (f), each private*  
34    *hospital shall be paid the sum of the following amounts as*  
35    *applicable for the provision of hospital inpatient services for each*  
36    *subject fiscal quarter:*

37    (1) *A general acute care per diem supplemental rate multiplied*  
38    *by the hospital's general acute care days.*

39    (2) *An acute psychiatric per diem supplemental rate multiplied*  
40    *by the hospital's acute psychiatric days.*



1     (3) *A high acuity per diem supplemental rate multiplied by the*  
2 *number of the hospital's high acuity days if the hospital's Medicaid*  
3 *inpatient utilization rate is less than the percent required to be*  
4 *eligible to receive disproportionate share replacement funds for*  
5 *the state fiscal year ending in the base calendar year and greater*  
6 *than 5 percent and at least 5 percent of the hospital's general*  
7 *acute care days are high acuity days.*

8     (4) *A high acuity trauma per diem supplemental rate multiplied*  
9 *by the number of the hospital's high acuity days if the hospital*  
10 *qualifies to receive the amount set forth in paragraph (3) and has*  
11 *been designated as a Level I, Level II, Adult/Ped Level I, or*  
12 *Adult/Ped Level II trauma center by the Emergency Medical*  
13 *Services Authority established pursuant to Section 1797.1 of the*  
14 *Health and Safety Code.*

15     (5) *A transplant per diem supplemental rate multiplied by the*  
16 *number of the hospital's transplant days if the hospital's Medicaid*  
17 *inpatient utilization rate is less than the percent required to be*  
18 *eligible to receive disproportionate share replacement funds for*  
19 *the state fiscal year ending in the base calendar year and greater*  
20 *than 5 percent.*

21     (6) *A payment for hospital inpatient services equal to the*  
22 *subacute supplemental rate multiplied by the Medi-Cal subacute*  
23 *payments as reflected in the state paid claims file prepared by the*  
24 *department as of the retrieval date for the base calendar year if*  
25 *the private hospital provided Medi-Cal subacute services during*  
26 *the base calendar year.*

27     (c) *In the event federal financial participation for a subject*  
28 *fiscal year is not available for all of the supplemental amounts*  
29 *payable to private hospitals under subdivision (b) due to the*  
30 *application of an upper payment limit or for any other reason,*  
31 *both of the following shall apply:*

32     (1) *The total amount payable to private hospitals under*  
33 *subdivision (b) for the subject fiscal year shall be reduced to reflect*  
34 *the amount for which federal financial participation is available.*

35     (2) *The amount payable under subdivision (b) to each private*  
36 *hospital for the subject fiscal year shall be equal to the amount*  
37 *computed under subdivision (b) multiplied by the ratio of the total*  
38 *amount for which federal financial participation is available to*  
39 *the total amount computed under subdivision (b).*

1 (d) If the amount otherwise payable to a hospital under this  
2 section for a subject fiscal year exceeds the amount for which  
3 federal financial participation is available for that hospital, the  
4 amount due to the hospital for that subject fiscal year shall be  
5 reduced to the amount for which federal financial participation is  
6 available.

7 (e) Payments shall not be made under this section for the periods  
8 when a hospital is a new hospital during a program period.

9 (f) Payments shall be made to a converted hospital that converts  
10 during a subject fiscal quarter by multiplying the hospital's  
11 outpatient supplemental payment as calculated in subdivision (b)  
12 by the number of days that the hospital was a private hospital in  
13 the subject fiscal quarter, divided by the number of days in the  
14 subject fiscal quarter. Payments shall not be made to a converted  
15 hospital in any subsequent subject fiscal quarter.

16 14169.56. (a) The department shall increase capitation  
17 payments to Medi-Cal managed health care plans for each subject  
18 fiscal year as set forth in this section.

19 (b) (1) Subject to the limitation in paragraph (2), the increased  
20 capitation payments shall be made as part of the monthly capitated  
21 payments made by the department to managed health care plans.  
22 The aggregate amount of increased capitation payments to all  
23 Medi-Cal managed health care plans for each subject fiscal year,  
24 or portion thereof, shall be the maximum amount for which federal  
25 financial participation is available on an aggregate statewide  
26 basis for the applicable subject fiscal year within a program  
27 period, or portion thereof.

28 (2) (A) The limitation in subparagraph (B) shall be applied  
29 with respect to a subject fiscal year or portion thereof for which  
30 the federal matching assistance percentage is less than 90  
31 percentage for expenditures for services furnished to individuals  
32 who meet the eligibility requirements in Section  
33 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security  
34 Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)), and who meet the  
35 conditions described in Section 1905(y) of the federal Social  
36 Security Act (42 U.S.C. Sec. 1396d(y)).

37 (B) During a subject fiscal year or portion thereof described in  
38 subparagraph (A), the aggregate amount of the increased  
39 capitation payments under this section shall not exceed the  
40 aggregate amount of the increased capitation payments that would

1 *be made if the nonfederal share of the increased capitation*  
 2 *payments were the amount that the nonfederal share would have*  
 3 *been if the federal matching assistance percentage were 90 percent*  
 4 *for expenditures for services furnished to individuals who meet*  
 5 *the eligibility requirements in Section 1902(a)(10)(A)(i)(VIII) of*  
 6 *Title XIX of the federal Social Security Act (42 U.S.C. Sec.*  
 7 *1396a(a)(10)(A)(i)(VIII)), and who meet the conditions described*  
 8 *in Section 1905(y) of the federal Social Security Act (42 U.S.C.*  
 9 *Sec. 1396d(y)).*

10 *(c) The department shall determine the amount of the increased*  
 11 *capitation payments for each managed health care plan for each*  
 12 *subject fiscal year or portion thereof during a program period.*  
 13 *The department shall consider the composition of Medi-Cal*  
 14 *enrollees in the plan, the anticipated utilization of hospital services*  
 15 *by the plan's Medi-Cal enrollees, and other factors that the*  
 16 *department determines are reasonable and appropriate to ensure*  
 17 *access to high-quality hospital services by the plan's enrollees.*

18 *(d) The amount of increased capitation payments to each*  
 19 *Medi-Cal managed health care plan shall not exceed an amount*  
 20 *that results in capitation payments that are certified by the state's*  
 21 *actuary as meeting federal requirements, taking into account the*  
 22 *requirement that all of the increased capitation payments under*  
 23 *this section shall be paid by the Medi-Cal managed health care*  
 24 *plans to hospitals for hospital services to Medi-Cal enrollees of*  
 25 *the plan.*

26 *(e) (1) The increased capitation payments to managed health*  
 27 *care plans under this section shall be made to support the*  
 28 *availability of hospital services and ensure access to hospital*  
 29 *services for Medi-Cal beneficiaries. The increased capitation*  
 30 *payments to managed health care plans shall commence within*  
 31 *90 days after the date on which all necessary federal approvals*  
 32 *have been received, and shall include, but not be limited to, the*  
 33 *sum of the increased payments for all prior months for which*  
 34 *payments are due.*

35 *(2) To secure the necessary funding for the payment or payments*  
 36 *made pursuant to paragraph (1), the department may accumulate*  
 37 *funds in the Hospital Quality Assurance Revenue Fund, established*  
 38 *pursuant to Section 14167.35, for the purpose of funding managed*  
 39 *health care capitation payments under this article regardless of*  
 40 *the date on which capitation payments are scheduled to be paid*

1 in order to secure the necessary total funding for managed health  
2 care payments by the end of a program period.

3 (f) Payments to managed health care plans that would be paid  
4 consistent with actuarial certification and enrollment in the  
5 absence of the payments made pursuant to this section, including,  
6 but not limited to, payments described in Section 14182.15, shall  
7 not be reduced as a consequence of payments under this section.

8 (g) (1) Each managed health care plan shall expend 100 percent  
9 of any increased capitation payments it receives under this section  
10 on hospital services as provided in Section 14169.57.

11 (2) The department may issue change orders to amend contracts  
12 with managed health care plans as needed to adjust monthly  
13 capitation payments in order to implement this section.

14 (3) For entities contracting with the department pursuant to  
15 Article 2.91 (commencing with Section 14089), any incremental  
16 increase in capitation rates pursuant to this section shall not be  
17 subject to negotiation and approval by the department.

18 (h) (1) In the event federal financial participation is not  
19 available for all of the increased capitation payments determined  
20 for a month pursuant to this section for any reason, the increased  
21 capitation payments mandated by this section for that month shall  
22 be reduced proportionately to the amount for which federal  
23 financial participation is available.

24 (2) The determination under this subdivision for any month in  
25 a program period shall be made after accounting for all federal  
26 financial participation necessary for full implementation of Section  
27 14182.15 for that month.

28 14169.57. (a) Each managed health care plan receiving  
29 increased capitation payments under Section 14169.56 shall expend  
30 the capitation rate increases in a manner consistent with actuarial  
31 certification, enrollment, and utilization on hospital services. Each  
32 managed health care plan shall expend increased capitation  
33 payments on hospital services within 30 days of receiving the  
34 increased capitation payments to the extent they are made for a  
35 subject month that is prior to the date on which the payments are  
36 received by the managed health care plan.

37 (b) The sum of all expenditures made by a managed health care  
38 plan for hospital services pursuant to this section shall equal, or  
39 approximately equal, all increased capitation payments received  
40 by the managed health care plan, consistent with actuarial

1 *certification, enrollment, and utilization, from the department*  
2 *pursuant to Section 14169.56.*

3 *(c) Any delegation or attempted delegation by a managed health*  
4 *care plan of its obligation to expend the capitation rate increases*  
5 *under this section shall not relieve the plan from its obligation to*  
6 *expend those capitation rate increases. Managed health care plans*  
7 *shall submit the documentation that the department may require*  
8 *to demonstrate compliance with this subdivision. The*  
9 *documentation shall demonstrate actual expenditure of the*  
10 *capitation rate increases for hospital services, and not assignment*  
11 *to subcontractors of the managed health care plan's obligation of*  
12 *the duty to expend the capitation rate increases.*

13 *(d) The supplemental hospital payments made by managed*  
14 *health care plans pursuant to this section shall reflect the overall*  
15 *purpose of this article.*

16 *(e) This article is not intended to create a private right of action*  
17 *by a hospital against a managed care plan provided that the*  
18 *managed health care plan expends all increased capitation*  
19 *payments for hospital services.*

20 *14169.58. (a) (1) For the first program period, designated*  
21 *public hospitals shall be paid direct grants in support of health*  
22 *care expenditures, which shall not constitute Medi-Cal payments,*  
23 *and which shall be funded by the quality assurance fee set forth*  
24 *in this article. For the first program period, the aggregate amount*  
25 *of the grants to designated public hospitals funded by the quality*  
26 *assurance fee set forth in this article shall be forty-five million*  
27 *dollars (\$45,000,000) in the aggregate for the two subject fiscal*  
28 *quarters in the 2013–14 subject fiscal year, ninety-three million*  
29 *dollars (\$93,000,000) for the 2014–15 subject fiscal year, one*  
30 *hundred ten million five hundred thousand dollars (\$110,500,000)*  
31 *for the 2015–16 subject fiscal year, and sixty-two million five*  
32 *hundred thousand dollars (\$62,500,000) in the aggregate for the*  
33 *two subject fiscal quarters in the 2016–17 subject fiscal year.*

34 *(2) (A) Of the direct grant amounts set forth in paragraph (1),*  
35 *the director shall allocate twenty-four million five hundred*  
36 *thousand dollars (\$24,500,000) in the aggregate for the two subject*  
37 *fiscal quarters in the 2013–14 subject fiscal year, fifty million five*  
38 *hundred thousand dollars (\$50,500,000) for the 2014–15 subject*  
39 *fiscal year, sixty million five hundred thousand dollars*  
40 *(\$60,500,000) for the 2015–16 subject fiscal year, and thirty-four*

1 million five hundred thousand dollars (\$34,500,000) in the  
2 aggregate for the two subject fiscal quarters in the 2016–17 subject  
3 fiscal year among the designated public hospitals pursuant to a  
4 methodology developed in consultation with the designated public  
5 hospitals.

6 (B) Of the direct grant amounts set forth in subparagraph (A),  
7 the director shall distribute six million one hundred twenty-five  
8 thousand dollars (\$6,125,000) for each subject fiscal quarter in  
9 the 2013–14 subject fiscal year, six million three hundred twelve  
10 thousand five hundred dollars (\$6,312,500) for each subject fiscal  
11 quarter in the 2014–15 subject fiscal year, seven million five  
12 hundred sixty-two thousand five hundred dollars (\$7,562,500) for  
13 each subject fiscal quarter in the 2015–16 subject fiscal year, and  
14 eight million six hundred twenty-five thousand dollars (\$8,625,000)  
15 for each subject fiscal quarter in the 2016–17 subject fiscal year  
16 in accordance with the timeframes specified in subdivision (a) of  
17 Section 14169.66.

18 (C) Of the direct grant amounts set forth in subparagraph (A),  
19 the director shall distribute six million one hundred twenty-five  
20 thousand dollars (\$6,125,000) for each subject fiscal quarter in  
21 the 2013–14 subject fiscal year, six million three hundred twelve  
22 thousand five hundred dollars (\$6,312,500) for each subject fiscal  
23 quarter in the 2014–15 subject fiscal year, seven million five  
24 hundred sixty-two thousand five hundred dollars (\$7,562,500) for  
25 each subject fiscal quarter in the 2015–16 subject fiscal year, and  
26 eight million six hundred twenty-five thousand dollars (\$8,625,000)  
27 for each subject fiscal quarter in the 2016–17 subject fiscal year  
28 only upon 100 percent of the rate range increases being distributed  
29 to managed health care plans pursuant to subparagraph (D) for  
30 the respective subject fiscal quarter. If the rate range increases  
31 pursuant to subparagraph (D) are distributed to managed health  
32 care plans, the direct grant amounts described in this  
33 subparagraph shall be distributed to designated public hospitals  
34 no later than 30 days after the rate range increases have been  
35 distributed to managed health care plans pursuant to subparagraph  
36 (D).

37 (D) Of the direct grant amounts set forth in paragraph (1),  
38 twenty million five hundred thousand dollars (\$20,500,000) in the  
39 aggregate for the two subject fiscal quarters in the 2013–14 subject  
40 fiscal year, forty two million five hundred thousand dollars

1 (\$42,500,000) for the 2014–15 subject fiscal year, fifty million  
2 dollars (\$50,000,000) for the 2015–16 subject fiscal year, and  
3 twenty-eight million dollars (\$28,000,000) in the aggregate for  
4 the two subject fiscal quarters in the 2016–17 subject fiscal year  
5 shall be withheld from payment to the designated public hospitals  
6 by the director, and shall be used as the nonfederal share for rate  
7 range increases, as defined in paragraph (4) of subdivision (b) of  
8 Section 14301.4, to risk-based payments to managed care health  
9 plans that contract with the department to serve counties where a  
10 designated public hospital is located. The rate range increases  
11 shall apply to managed care rates for beneficiaries other than  
12 newly eligible beneficiaries, as defined in subdivision (s) of Section  
13 17612.2, and shall enable plans to compensate hospitals for  
14 Medi-Cal health services and to support the Medi-Cal program.  
15 Each managed health care plan shall expend 100 percent of the  
16 rate range increases on hospital services within 30 days of  
17 receiving the increased payments. Rate range increases funded  
18 under this subparagraph shall be allocated among plans pursuant  
19 to a methodology developed in consultation with the hospital  
20 community.

21 (3) Notwithstanding any other provision of law, any amounts  
22 withheld from payment to the designated public hospitals by the  
23 director as the nonfederal share for rate range increases, including  
24 those described in subparagraph (D) of paragraph (2), shall not  
25 be considered hospital fee direct grants as defined under  
26 subdivision (k) of Section 17612.2 and shall not be included in the  
27 determination under paragraph (1) of subdivision (a) of Section  
28 17612.3.

29 (b) (1) For the first program period, nondesignated public  
30 hospitals shall be paid direct grants in support of health care  
31 expenditures, which shall not constitute Medi-Cal payments, and  
32 which shall be funded by the quality assurance fee set forth in this  
33 article. For the first program period, the aggregate amount of the  
34 grants funded by the quality assurance fee set forth in this article  
35 to nondesignated public hospitals shall be twelve million five  
36 hundred thousand dollars (\$12,500,000) in the aggregate for two  
37 subject fiscal quarters in the 2013–14 subject fiscal year,  
38 twenty-five million dollars (\$25,000,000) for the 2014–15 subject  
39 fiscal year, thirty million dollars (\$30,000,000) for the 2015–16  
40 subject fiscal year, and seventeen million five hundred thousand

1 dollars (\$17,500,000) in the aggregate for the two subject fiscal  
2 quarters in the 2016–17 subject fiscal year.

3 (2) (A) Of the direct grant amounts set forth in paragraph (1),  
4 the director shall allocate two million five hundred thousand  
5 dollars (\$2,500,000) in the aggregate for the two subject fiscal  
6 quarters in the 2013–14 subject fiscal year, five million dollars  
7 (\$5,000,000) for the 2014–15 subject fiscal year, six million dollars  
8 (\$6,000,000) for the 2015–16 subject fiscal year, and three million  
9 five hundred thousand dollars (\$3,500,000) in the aggregate for  
10 the two subject fiscal quarters in the 2016–17 subject fiscal year  
11 among the nondesignated public hospitals pursuant to a  
12 methodology developed in consultation with the nondesignated  
13 public hospitals.

14 (B) Of the direct grant amounts set forth in paragraph (1), ten  
15 million dollars (\$10,000,000) in the aggregate for the two subject  
16 fiscal quarters in the 2013–14 subject fiscal year, twenty million  
17 dollars (\$20,000,000) for the 2014–15 subject fiscal year, twenty  
18 four million dollars (\$24,000,000) for the 2015–16 subject fiscal  
19 year, and fourteen million dollars (\$14,000,000) in the aggregate  
20 for the two subject fiscal quarters in the 2016–17 subject fiscal  
21 year shall be withheld from payment to the nondesignated public  
22 hospitals by the director, and shall be used as the nonfederal share  
23 for rate range increases, as defined in paragraph (4) of subdivision  
24 (b) of Section 14301.4, to risk-based payments to managed care  
25 health plans that contract with the department. The rate range  
26 increases shall enable plans to compensate hospitals for Medi-Cal  
27 health services and to support the Medi-Cal program. Each  
28 managed health care plan shall expend 100 percent of the rate  
29 range increases on hospital services within 30 days of receiving  
30 the increased payments. Rate range increases funded under this  
31 subparagraph shall be allocated among plans pursuant to a  
32 methodology developed in consultation with the hospital  
33 community.

34 (c) If the amounts set forth in this section for rate range  
35 increases are not actually used for rate range increases as  
36 described in this section, the direct grant amounts set forth in this  
37 section that are withheld pursuant to subparagraph (D) of  
38 paragraph (2) of subdivision (a) and subparagraph (B) of  
39 paragraph (2) of subdivision (b) shall be returned the Hospital



1 *Quality Assurance Revenue Fund subject to paragraph (4) of*  
2 *subdivision (l) of Section 14169.52.*

3 *(d) For subsequent program periods, designated public hospitals*  
4 *and nondesignated public hospitals may be paid direct grants*  
5 *pursuant to subdivision (e) of Section 14169.59 upon appropriation*  
6 *in the annual Budget Act.*

7 *14169.59. (a) The department shall determine during each*  
8 *rebase calculation year the number of subject fiscal years in the*  
9 *next program period.*

10 *(b) During each rebase calculation year, the department shall*  
11 *retrieve the data, including, but not limited to, the days data source,*  
12 *used to determine the following for the subsequent program period:*  
13 *acute psychiatric days, annual fee-for-service days, annual*  
14 *managed care days, annual Medi-Cal days, fee-for-service days,*  
15 *general acute care days, high acuity days, managed care days,*  
16 *Medi-Cal days, Medi-Cal fee-for-service days, Medi-Cal managed*  
17 *care days, Medi-Cal managed care fee days, outpatient base*  
18 *amount, and transplant days. The department shall pull data from*  
19 *the most recent base calendar year for which the department*  
20 *determines reliable data is available for all hospitals.*

21 *(c) During each rebase calculation year, the department shall*  
22 *determine all of the following rates for the subsequent program*  
23 *period, which rates shall be specified in provisional language in*  
24 *the annual Budget Act:*

25 *(1) The acute psychiatric per diem supplemental rate for each*  
26 *subject fiscal year during the program period.*

27 *(2) The fee-for-service per diem quality assurance fee rate for*  
28 *each subject fiscal year during the program period.*

29 *(3) The general acute care per diem supplemental rate for each*  
30 *subject fiscal year during the program period.*

31 *(4) The high acuity per diem supplemental rate for each subject*  
32 *fiscal year during the program period.*

33 *(5) The high acuity trauma per diem supplemental rate for each*  
34 *subject fiscal year during the program period.*

35 *(6) The managed care per diem quality assurance fee rate for*  
36 *each subject fiscal year during the program period.*

37 *(7) The Medi-Cal per diem quality assurance fee rate for each*  
38 *subject fiscal year during the program period.*

39 *(8) The outpatient supplemental rate for each subject fiscal year*  
40 *during the program period.*

1     (9) *The prepaid health plan hospital managed care per diem*  
2 *quality assurance fee rate for each subject fiscal year during the*  
3 *program period.*

4     (10) *The prepaid health plan hospital Medi-Cal managed care*  
5 *per diem quality assurance fee rate for each subject fiscal year*  
6 *during the program period.*

7     (11) *The subacute supplemental rate for each subject fiscal year*  
8 *during the program period.*

9     (12) *The transplant per diem supplemental rate for each subject*  
10 *fiscal year during the program period.*

11     (d) *The department shall determine the rates set forth in*  
12 *paragraph (1) to (12), inclusive, of subdivision (c) based on the*  
13 *data retrieved pursuant to subdivision (b). Each rate determined*  
14 *by the department shall be the same for all hospitals to which the*  
15 *rate applies. These rates shall be specified in provisional language*  
16 *in the annual Budget Act. The department shall determine the rates*  
17 *in accordance with all of the following:*

18     (1) *The rates shall meet the requirements of federal law and be*  
19 *established in a manner to obtain federal approval.*

20     (2) *The department shall consult with the hospital community*  
21 *in determining the rates.*

22     (3) *The supplemental payments and other Medi-Cal payments*  
23 *for hospital outpatient services furnished by private hospitals for*  
24 *each fiscal year shall equal as close as possible the applicable*  
25 *federal upper payment limit.*

26     (4) *The supplemental payments and other Medi-Cal payments*  
27 *for hospital inpatient services furnished by private hospitals for*  
28 *each fiscal year shall equal as close as possible the applicable*  
29 *federal upper payment limit.*

30     (5) *The increased capitation payments to managed health care*  
31 *plans shall result in the maximum payments to the plans permitted*  
32 *by federal law.*

33     (6) *The quality assurance fee proceeds shall be adequate to*  
34 *make the expenditures described in this article, but shall not be*  
35 *more than necessary to make the expenditures.*

36     (7) *The relative values of per diem supplemental payment rates*  
37 *to one another for the various categories of patient days shall be*  
38 *generally consistent with the relative values during the first*  
39 *program period under this article.*

1     (8) *The relative values of per diem fee rates to one another for*  
2 *the various categories of patient days shall be generally consistent*  
3 *with the relative values during the first program period under this*  
4 *article.*

5     (9) *The rates shall result in supplemental payments and quality*  
6 *assurance fees that are consistent with the purposes of this article.*

7     (e) *During each rebase calculation year, the director shall*  
8 *determine the amounts and allocation methodology, if any, of*  
9 *direct grants to designated public hospitals and nondesignated*  
10 *public hospitals for each subject fiscal year in a program period,*  
11 *in consultation with the hospital community. The amounts and*  
12 *allocation methodology may include a withhold of direct grants*  
13 *to be used as the nonfederal share for rate range increases. These*  
14 *amounts shall be specified in provisional language in the annual*  
15 *Budget Act.*

16     (f) *Notwithstanding any other provision in this article, the*  
17 *following shall apply to the first program period under this article:*

18     (1) *The first program period under this article shall be the*  
19 *period from January 1, 2014, to December 31, 2016, inclusive.*

20     (2) *The acute psychiatric days shall be those identified in the*  
21 *Final Medi-Cal Utilization Statistics for the 2012–13 state fiscal*  
22 *year as calculated by the department as of December 17, 2012.*

23     (3) *The acute psychiatric per diem supplemental rate shall be*  
24 *nine hundred sixty-five dollars (\$965) for the two remaining subject*  
25 *fiscal quarters in the 2013–14 subject fiscal year, nine hundred*  
26 *seventy dollars (\$970) for the subject fiscal quarters in the 2014–15*  
27 *subject fiscal year, nine hundred seventy-five dollars (\$975) for*  
28 *the subject fiscal quarters in the 2015–16 subject fiscal year and*  
29 *nine hundred seventy-five dollars (\$975) for the first two subject*  
30 *fiscal quarters in the 2016–17 subject fiscal year.*

31     (4) *The days data source shall be the hospital's Annual*  
32 *Financial Disclosure Report filed with the Office of Statewide*  
33 *Health Planning and Development as of June 6, 2013, for its fiscal*  
34 *year ending during the 2010 calendar year.*

35     (5) *The fee-for-service per diem quality assurance fee rate shall*  
36 *be three hundred seventy-four dollars and ninety-one cents*  
37 *(\$374.91) for the two remaining subject fiscal quarters in the*  
38 *2013–14 subject fiscal year, four hundred twenty-five dollars and*  
39 *twenty-two cents (\$425.22) for the subject fiscal quarters in the*  
40 *2014–15 subject fiscal year, four hundred eighty dollars and eleven*

1 cents (\$480.11) for the subject fiscal quarters in the 2015–16  
2 subject fiscal year, and five hundred forty-two dollars and ten  
3 cents (\$542.10) for the first two subject fiscal quarters in the  
4 2016–17 subject fiscal year.

5 (6) The general acute care days shall be those identified in the  
6 2010 calendar year, as reflected in the state paid claims file on  
7 April 26, 2013.

8 (7) The general acute care per diem supplemental rate shall be  
9 eight hundred twenty-four dollars and forty cents (\$824.40) for  
10 the two remaining subject fiscal quarters in the 2013–14 subject  
11 fiscal year, one thousand one hundred ten dollars and sixty-seven  
12 cents (\$1,110.67) for the subject fiscal quarters in the 2014–15  
13 subject fiscal year, one thousand three hundred thirty-five dollars  
14 and forty-two cents (\$1,335.42) for the subject fiscal quarters in  
15 the 2015–16 subject fiscal year, and one thousand four hundred  
16 forty-one dollars and twenty cents (\$1,441.20) for the first two  
17 subject fiscal quarters in the 2016–17 subject fiscal year.

18 (8) The high acuity days shall be those paid during the 2010  
19 calendar year, as reflected in the state paid claims file prepared  
20 by the department on April 26, 2013.

21 (9) The high acuity per diem supplemental rate shall be two  
22 thousand five hundred dollars (\$2,500) for the two remaining  
23 subject fiscal quarters in the 2013–14 subject fiscal year, two  
24 thousand five hundred dollars (\$2,500) for the subject fiscal  
25 quarters in the 2014–15 subject fiscal year, two thousand five  
26 hundred dollars (\$2,500) for the subject fiscal quarters in the  
27 2015–16 subject fiscal year, and two thousand five hundred dollars  
28 (\$2,500) for the first two subject fiscal quarters in the 2016–17  
29 subject fiscal year.

30 (10) The high acuity trauma per diem supplemental rate shall  
31 be two thousand five hundred dollars (\$2,500) for the two  
32 remaining subject fiscal quarters in the 2013–14 subject fiscal  
33 year, two thousand five hundred dollars (\$2,500) for the subject  
34 fiscal quarters in the 2014–15 subject fiscal year, two thousand  
35 five hundred dollars (\$2,500) for the subject fiscal quarters in the  
36 2015–16 subject fiscal year, and two thousand five hundred dollars  
37 (\$2,500) for the first two subject fiscal quarters in the 2016–17  
38 subject fiscal year.

39 (11) The managed care per diem quality assurance fee rate  
40 shall be one hundred forty-five dollars (\$145) for the two remaining

1 *subject fiscal quarters in the 2013–14 subject fiscal year, one*  
2 *hundred forty-five dollars (\$145) for the subject fiscal quarters in*  
3 *the 2014–15 subject fiscal year, one hundred seventy dollars (\$170)*  
4 *for the subject fiscal quarters in the 2015–16 subject fiscal year,*  
5 *and one hundred seventy dollars (\$170) for the first two subject*  
6 *fiscal quarters in the 2016–17 subject fiscal year.*

7 *(12) The Medi-Cal managed care days shall be those identified*  
8 *in the Final Medi-Cal Utilization Statistics for the 2012–13 fiscal*  
9 *year, as calculated by the department as of December 17, 2012.*

10 *(13) The Medi-Cal per diem quality assurance fee rate shall be*  
11 *four hundred fifty-seven dollars and ten cents (\$457.10) for the*  
12 *two remaining subject fiscal quarters in the 2013–14 subject fiscal*  
13 *year, four hundred ninety-seven dollars and eight cents (\$497.08)*  
14 *for the subject fiscal quarters in the 2014–15 subject fiscal year,*  
15 *five hundred sixty-eight dollars and fifteen cents (\$568.15) for the*  
16 *subject fiscal quarters in the 2015–16 subject fiscal year, and six*  
17 *hundred eighteen dollars and fourteen cents (\$618.14) for the first*  
18 *two subject fiscal quarters in the 2016–17 subject fiscal year.*

19 *(14) The outpatient base amount shall be those payments for*  
20 *outpatient services made to a hospital in the 2010 calendar year,*  
21 *as reflected in the state paid claims files prepared by the*  
22 *department on April 26, 2013.*

23 *(15) The outpatient supplemental rate shall be 119 percent of*  
24 *the outpatient base amount for the two remaining subject fiscal*  
25 *quarters in the 2013–14 subject fiscal year, 268 percent of the*  
26 *outpatient base amount for the subject fiscal quarters in the*  
27 *2014–15 subject fiscal year, 292 percent of the outpatient base*  
28 *amount for the subject fiscal quarters in the 2015–16 subject fiscal*  
29 *year, and 151 percent of the outpatient base amount for the first*  
30 *two subject fiscal quarters in the 2016–17 subject fiscal year.*

31 *(16) The prepaid health plan hospital managed care per diem*  
32 *quality assurance fee rate shall be eighty-one dollars and twenty*  
33 *cents (\$81.20) for the two remaining subject fiscal quarters in the*  
34 *2013–14 subject fiscal year, eighty-one dollars and twenty cents*  
35 *(\$81.20) for the subject fiscal quarters in the 2014–15 subject*  
36 *fiscal year, ninety-five dollars and twenty cents (\$95.20) for the*  
37 *subject fiscal quarters in the 2015–16 subject fiscal year, and*  
38 *ninety-five dollars and twenty cents (\$95.20) for the first two*  
39 *subject fiscal quarters in the 2016–17 subject fiscal year.*

1     (17) *The prepaid health plan hospital Medi-Cal managed care*  
2 *per diem quality assurance fee rate shall be two hundred fifty-five*  
3 *dollars and ninety-seven cents (\$255.97) for the two remaining*  
4 *subject fiscal quarters in the 2013–14 subject fiscal year, two*  
5 *hundred seventy-eight dollars and thirty-seven cents (\$278.37) for*  
6 *the subject fiscal quarters in the 2014–15 subject fiscal year, three*  
7 *hundred eighteen dollars and sixteen cents (\$318.16) for the subject*  
8 *fiscal quarters in the 2015–16 subject fiscal year, and three*  
9 *hundred forty-six dollars and sixteen cents (\$346.16) for the first*  
10 *two subject fiscal quarters in the 2016–17 subject fiscal year.*

11     (18) *The subacute supplemental rate shall be 50 percent for the*  
12 *two remaining subject fiscal quarters in the 2013–14 subject fiscal*  
13 *year, 55 percent for the subject fiscal quarters in the 2014–15*  
14 *subject fiscal year, 60 percent for the subject fiscal quarters in the*  
15 *2015–16 subject fiscal year, and 60 percent for the first two subject*  
16 *fiscal quarters in the 2016–17 subject fiscal year of the Medi-Cal*  
17 *subacute payments paid by the department to the hospital during*  
18 *the 2010 calendar year, as reflected in the state paid claims file*  
19 *prepared by the department on April 26, 2013.*

20     (19) *The transplant days shall be those identified in the 2010*  
21 *Patient Discharge file from the Office of Statewide Health Planning*  
22 *and Development accessed on June 28, 2011.*

23     (20) *The transplant per diem supplemental rate shall be two*  
24 *thousand five hundred dollars (\$2,500) for the two remaining*  
25 *subject fiscal quarters in the 2013–14 subject fiscal year, two*  
26 *thousand five hundred dollars (\$2,500) for the subject fiscal*  
27 *quarters in the 2014–15 subject fiscal year, two thousand five*  
28 *hundred dollars (\$2,500) for the subject fiscal quarters in the*  
29 *2015–16 subject fiscal year, and two thousand five hundred dollars*  
30 *(\$2,500) for the first two subject fiscal quarters in the 2016–17*  
31 *subject fiscal year.*

32     (21) *Upon federal approval or conditional federal approval*  
33 *described in Section 14169.63, the director shall have the*  
34 *discretion to revise the fee-for-service per diem quality assurance*  
35 *fee rate, the managed care per diem quality assurance fee rate,*  
36 *the Medi-Cal per diem quality assurance fee rate, the prepaid*  
37 *health plan hospital managed care per diem quality assurance fee*  
38 *rate, or the prepaid health plan hospital Medi-Cal managed care*  
39 *per diem quality assurance fee rate, based on the funds required*

1 *to make the payments specified in this article, in consultation with*  
2 *the hospital community.*

3 *(22) With respect to a hospital described in subdivision (f) of*  
4 *Section 14165.50, both of the following shall apply:*

5 *(A) The hospital shall not be considered a new hospital as*  
6 *defined in subdivision (ah) of Section 14169.51 for the purposes*  
7 *of this article.*

8 *(B) To the extent permitted by federal law and other federal*  
9 *requirements, the department shall use the best available and*  
10 *reasonable current estimates or projections made with respect to*  
11 *the hospital for an annual period as the data, including, but not*  
12 *limited to, the days data source and data described as being*  
13 *derived from a state paid claims file, used for all purposes,*  
14 *including, but not limited to, the calculation of supplemental*  
15 *payments and the quality assurance fee. The estimates and*  
16 *projections shall be deemed to reflect paid claims and shall be*  
17 *used for each data element regardless of the time period otherwise*  
18 *applicable to the data element. The data elements include, but are*  
19 *not limited to, acute psychiatric days, annual fee-for-service days,*  
20 *annual managed care days, annual Medi-Cal days, fee-for-service*  
21 *days, general acute care days, high acuity days, managed care*  
22 *days, Medi-Cal days, Medi-Cal fee-for-service days, Medi-Cal*  
23 *managed care days, Medi-Cal managed care fee days, outpatient*  
24 *base amount, and transplant days.*

25 *(g) Notwithstanding any other provision in this article, the*  
26 *following shall apply to the second program period under this*  
27 *article:*

28 *(1) The second program period under this article shall begin*  
29 *on January 1, 2017, and shall end on June 30, 2019.*

30 *(2) The retrieval date shall occur between October 1, 2016, and*  
31 *December 31, 2016.*

32 *(3) The base calendar year shall be the 2013 calendar year, or*  
33 *a more recent calendar year for which the department determines*  
34 *reliable data is available.*

35 *(4) The rebase calculation year shall be the 2015–16 state fiscal*  
36 *year.*

37 *(5) With respect to a hospital described in subdivision (f) of*  
38 *Section 14165.50, both of the following shall apply:*

1 (A) *The hospital shall not be considered a new hospital as*  
2 *defined in subdivision (ah) of Section 14169.51 for the purposes*  
3 *of this article.*

4 (B) *To the extent permitted by federal law or other federal*  
5 *requirements, the department shall use the best available and*  
6 *reasonable current estimates or projections made with respect to*  
7 *the hospital for an annual period as to the data, including, but not*  
8 *limited to, the days data source and data described as being*  
9 *derived from a state paid claims file, used for all purposes,*  
10 *including, but not limited to, the calculation of supplemental*  
11 *payments and the quality assurance fee. The estimates and*  
12 *projections shall be deemed to reflect paid claims and shall be*  
13 *used for each data element regardless of the time period otherwise*  
14 *applicable to the data element. The data elements include, but are*  
15 *not limited to, acute psychiatric days, annual fee-for-service days,*  
16 *annual managed care days, annual Medi-Cal days, fee-for-service*  
17 *days, general acute care days, high acuity days, managed care*  
18 *days, Medi-Cal days, Medi-Cal fee-for-service days, Medi-Cal*  
19 *managed care days, Medi-Cal managed care fee days, outpatient*  
20 *base amount, and transplant days.*

21 (i) *Commencing January 2016, the department shall provide a*  
22 *clear narrative description along with fiscal detail in the Medi-Cal*  
23 *estimate package, submitted to the Legislature in January and*  
24 *May of each year, of all of the calculations made by the department*  
25 *pursuant to this section for the second program period and every*  
26 *program period thereafter.*

27 14169.60. (a) *The amount of any payments made under this*  
28 *article to private hospitals, including the amount of payments made*  
29 *under Sections 14169.54 and 14169.55 and additional payments*  
30 *to private hospitals by managed health care plans pursuant to*  
31 *Section 14169.57, shall not be included in the calculation of the*  
32 *low-income percent or the OBRA 1993 payment limitation, as*  
33 *defined in paragraph (24) of subdivision (a) of Section 14105.98,*  
34 *for purposes of determining payments to private hospitals.*

35 (b) *The supplemental payments and other payments under this*  
36 *article shall be regarded as quality assurance payments, the*  
37 *implementation or suspension of which does not affect a*  
38 *determination of the adequacy of any rates under federal law.*

39 14169.61. (a) (1) *Except as provided in this section, all data*  
40 *and other information relating to a hospital that are used for the*



1 *purposes of this article, including, without limitation, the days*  
2 *data source, shall continue to be used to determine the payments*  
3 *to that hospital, regardless of whether the hospital has undergone*  
4 *one or more changes of ownership.*

5 *(2) All supplemental payments to a hospital under this article*  
6 *shall be made to the licensee of a hospital on the date the*  
7 *supplemental payment is made. All quality assurance fee payments*  
8 *under this article shall be paid by the licensee of a hospital on the*  
9 *date the quarterly quality assurance fee payment is due.*

10 *(b) The data of separate facilities prior to a consolidation shall*  
11 *be aggregated for the purposes of this article if: (1) a private*  
12 *hospital consolidates with another private hospital, (2) the facilities*  
13 *operate under a consolidated hospital license, (3) data for a period*  
14 *prior to the consolidation is used for purposes of this article, and*  
15 *(4) neither hospital has had a change of ownership on or after the*  
16 *effective date of this article unless paragraph (2) of subdivision*  
17 *(d) has been satisfied by the new owner. Data of a facility that was*  
18 *a separately licensed hospital prior to the consolidation shall not*  
19 *be included in the data, including the days data source, for the*  
20 *purpose of determining payments to the facility or the quality*  
21 *assurance fees due from the facility under the article for any time*  
22 *period during which the facility is closed. A facility shall be deemed*  
23 *to be closed for purposes of this subdivision on the first day of any*  
24 *period during which the facility has no general acute, psychiatric,*  
25 *or rehabilitation inpatients for at least 30 consecutive days. A*  
26 *facility that has been deemed to be closed under this subdivision*  
27 *shall no longer be deemed to be closed on the first subsequent day*  
28 *on which it has general acute, psychiatric, or rehabilitation*  
29 *inpatients.*

30 *(c) The payments to a hospital under this article shall not be*  
31 *made, and the quality assurance fees shall not be due, for any*  
32 *period during which the hospital is closed. A hospital shall be*  
33 *deemed to be closed on the first day of any period during which*  
34 *the hospital has no general acute, psychiatric or rehabilitation*  
35 *inpatients for at least 30 consecutive days. A hospital that has*  
36 *been deemed to be closed under this subdivision shall no longer*  
37 *be deemed to be closed on the first subsequent day on which it has*  
38 *general acute, psychiatric or rehabilitation inpatients. Payments*  
39 *under this article to a hospital and installment payments of the*  
40 *aggregate quality assurance fee due from a hospital that is closed*

1 during any portion of a subject fiscal quarter shall be reduced by  
2 applying a fraction, expressed as a percentage, the numerator of  
3 which shall be the number of days during the applicable subject  
4 fiscal quarter that the hospital is closed during the subject fiscal  
5 year and the denominator of which shall be the number of days in  
6 the subject fiscal quarter.

7 (d) The following provisions shall apply only for purposes of  
8 this article, and shall have no application outside of this article  
9 nor shall they affect the assumption of any outstanding monetary  
10 obligation to the Medi-Cal program:

11 (1) The director shall develop and describe in provider bulletins  
12 and on the department's Internet Web site a process by which the  
13 new operator of a hospital that has a days data source in whole  
14 or in part from a previous operator may enter into an agreement  
15 with the department to confirm that it is financially responsible  
16 or to become financially responsible to the department for the  
17 outstanding monetary obligation to the Medi-Cal program of the  
18 previous operator in order to avoid being classified as a new  
19 hospital for purposes of this article. This process shall be available  
20 for changes of ownership that occur before, on, or after January  
21 1, 2014, but only in regard to payments under this article and  
22 otherwise shall have no retroactive effect.

23 (2) The outstanding monetary obligation referred to in  
24 subdivision (ah) of Section 14169.51 shall include responsibility  
25 for all of the following:

26 (A) Payment of the quality assurance fee established pursuant  
27 to this article.

28 (B) Known overpayments that have been asserted by the  
29 department or its fiscal intermediary by sending a written  
30 communication that is received by the hospital prior to the date  
31 that the new operator becomes the licensee of the hospital.

32 (C) Overpayments that are asserted after such date and arise  
33 from customary reconciliations of payments, such as cost report  
34 settlements, and, with the exception of overpayments described in  
35 subparagraph (B), shall exclude liabilities arising from the  
36 fraudulent or intentionally criminal act of a prior operator if the  
37 new operator did not knowingly participate in or continue the  
38 fraudulent or criminal act after becoming the licensee.

39 (3) The department shall have the discretion to determine  
40 whether the new owner properly and fully agreed to be financially

1 responsible for the outstanding monetary obligation in connection  
2 with the Medi-Cal program and seek additional assurances as the  
3 department deems necessary, except that a new owner that executes  
4 an agreement with the department to be financially responsible  
5 for the monetary obligations as described in paragraph (1) shall  
6 be conclusively deemed to have agreed to be financially responsible  
7 for the outstanding monetary obligation in connection with the  
8 Medi-Cal program. The department shall have the discretion to  
9 establish the terms for satisfying the outstanding monetary  
10 obligation in connection with the Medi-Cal program, including,  
11 but not limited to, recoupment from amounts payable to the hospital  
12 under this section.

13 14169.62. Notwithstanding any provision in this article, the  
14 director may correct any identified material and egregious errors  
15 in the data, including, but not limited to, the days data source,  
16 used for the following: acute psychiatric days, annual  
17 fee-for-service days, annual managed care days, annual Medi-Cal  
18 days, fee-for-service days, general acute care days, high acuity  
19 days, managed care days, Medi-Cal days, Medi-Cal fee-for-service  
20 days, Medi-Cal managed care days, Medi-Cal managed care fee  
21 days, outpatient base amount, and transplant days. An error is  
22 material and egregious if the error is clear to the director based  
23 on information the director finds to be reliable and results in an  
24 increase or decrease to a hospital's supplemental payment amounts  
25 under this article, or in a hospital's quality assurance fee payments,  
26 of at least one million dollars (\$1,000,000) for any subject fiscal  
27 year. The director's determination whether to exercise his or her  
28 discretion under this section and any determination made by the  
29 director under this section shall not be subject to judicial review,  
30 except that a hospital may bring a writ of mandate under Section  
31 1085 of the Code of Civil Procedure to rectify an abuse of  
32 discretion by the department in correcting that hospital's data  
33 when that correction results in greater fees for that hospital  
34 pursuant to Sections 14169.52 and 14169.53 or lower supplemental  
35 payments for that hospital pursuant to Section 14169.54 and  
36 14169.55.

37 14169.63. (a) Notwithstanding any other provision of this  
38 article requiring federal approvals, the department may impose  
39 and collect the quality assurance fee and may make payments  
40 under this article, including increased capitation payments, based

1 upon receiving a letter from the federal Centers for Medicare and  
2 Medicaid Services or the United States Department of Health and  
3 Human Services that indicates likely federal approval, but only if  
4 and to the extent that the letter is sufficient as set forth in  
5 subdivision (b).

6 (b) In order for the letter to be sufficient under this section, the  
7 director shall find that the letter meets both of the following  
8 requirements:

9 (1) The letter is in writing and signed by an official of the federal  
10 Centers for Medicare and Medicaid Services or an official of the  
11 United States Department of Health and Human Services.

12 (2) The director, after consultation with the hospital community,  
13 has determined, in the exercise of his or her sole discretion, that  
14 the letter provides a sufficient level of assurance to justify advanced  
15 implementation of the fee and payment provisions.

16 (c) Nothing in this section shall be construed as modifying the  
17 requirement under Section 14169.69 that payments shall be made  
18 only to the extent a sufficient amount of funds collected as the  
19 quality assurance fee are available to cover the nonfederal share  
20 of those payments.

21 (d) Upon notice from the federal government that final federal  
22 approval for the fee model under this article or for the  
23 supplemental payments to private hospitals under Section 14169.54  
24 or 14169.55 has been denied, any fees collected pursuant to this  
25 section shall be refunded and any payments made pursuant to this  
26 article shall be recouped, including, but not limited to,  
27 supplemental payments and grants, increased capitation payments,  
28 payments to hospitals by health care plans resulting from the  
29 increased capitation payments, and payments for the health care  
30 coverage of children. To the extent fees were paid by a hospital  
31 that also received payments under this section, the payments may  
32 first be recouped from fees that would otherwise be refunded to  
33 the hospital prior to the use of any other recoupment method  
34 allowed under law.

35 (e) Any payment made pursuant to this section shall be a  
36 conditional payment until final federal approval has been received.

37 (f) The director shall have broad authority under this section  
38 to collect the quality assurance fee for an interim period after  
39 receipt of the letter described in subdivision (a) pending receipt

1 of all necessary federal approvals. This authority shall include  
2 discretion to determine both of the following:

3 (1) Whether the quality assurance fee should be collected on a  
4 full or pro rata basis during the interim period.

5 (2) The dates on which payments of the quality assurance fee  
6 are due.

7 (g) The department may draw against the Hospital Quality  
8 Assurance Revenue Fund for all administrative costs associated  
9 with implementation under this article, consistent with subdivision  
10 (b) of Section 14169.53.

11 (h) This section shall be implemented only to the extent federal  
12 financial participation is not jeopardized by implementation prior  
13 to the receipt of all necessary final federal approvals.

14 14169.64. (a) Notwithstanding any other provision in this  
15 article, the director may modify any timeline or timelines related  
16 to the assessment of the quality assurance fee or Medi-Cal  
17 payments under this article, including capitation payments, if the  
18 director, upon consultation with the hospital community,  
19 determines that it is impossible from an operational perspective  
20 to implement a timeline or timelines without the modification.

21 (b) The department shall notify the Joint Budget Legislative  
22 Committee and the fiscal and appropriate policy committees of  
23 the Legislature five working days prior to implementing a modified  
24 timeline or timelines under subdivision (a).

25 (c) The department shall consult with representatives of the  
26 hospital community in developing a modified timeline or timelines  
27 pursuant to this section.

28 (d) The discretion to modify timelines under this section shall  
29 include, but not be limited to, discretion to accelerate payments  
30 to plans or hospitals.

31 14169.65. (a) Upon receipt of a letter that indicates likely  
32 federal approval that the director determines is sufficient for  
33 implementation under Section 14169.63, or upon the receipt of  
34 federal approval, the following shall occur:

35 (1) To the maximum extent possible, and consistent with the  
36 availability of funds in the Hospital Quality Assurance Revenue  
37 Fund, the department shall make all of the payments under Sections  
38 14169.54, 14169.55, and 14169.56, including, but not limited to,  
39 supplemental payments and increased capitation payments, prior  
40 to the end of a program period, except that the increased capitation

1 *payments under Section 14169.56 shall not be made until federal*  
2 *approval is obtained for these payments.*

3 *(2) The department shall make supplemental payments to*  
4 *hospitals under this article consistent with the timeframe described*  
5 *in Section 14169.66 or a modified timeline developed pursuant to*  
6 *Section 14169.64.*

7 *(b) If any payment or payments made pursuant to this section*  
8 *are found to be inconsistent with federal law, the department shall*  
9 *recoup the payments by means of withholding or any other*  
10 *available remedy.*

11 *(c) This section shall not affect the department's ongoing*  
12 *authority to continue, after the end of a program period, to collect*  
13 *quality assurance fees imposed on or before the end of the program*  
14 *period.*

15 *14169.66. The department shall make disbursements from the*  
16 *Hospital Quality Assurance Revenue Fund consistent with the*  
17 *following:*

18 *(a) Fund disbursements shall be made periodically within 15*  
19 *days of each date on which quality assurance fees are due from*  
20 *hospitals.*

21 *(b) The funds shall be disbursed in accordance with the order*  
22 *of priority set forth in subdivision (b) of Section 14169.53, except*  
23 *that funds may be set aside for increased capitation payments to*  
24 *managed care health plans pursuant to subdivision (e) of Section*  
25 *14169.56.*

26 *(c) The funds shall be disbursed in each payment cycle in*  
27 *accordance with the order of priority set forth in subdivision (b)*  
28 *of Section 14169.53 as modified by subdivision (b), and so that*  
29 *the supplemental payments and direct grants to hospitals and the*  
30 *increased capitation payments to managed health care plans are*  
31 *made to the maximum extent for which funds are available.*

32 *(d) To the maximum extent possible, consistent with the*  
33 *availability of funds in the Hospital Quality Assurance Revenue*  
34 *Fund and the timing of federal approvals, the supplemental*  
35 *payments and direct grants to hospitals and increased capitation*  
36 *payments to managed health care plans under this article shall be*  
37 *made before the last day of a program period.*

38 *(e) The aggregate amount of funds to be disbursed to private*  
39 *hospitals shall be determined under Sections 14169.54 and*  
40 *14169.55. The aggregate amount of funds to be disbursed to*

1 *managed health care plans shall be determined under Section*  
2 *14169.56. The aggregate amount of direct grants to designated*  
3 *and nondesignated public hospitals shall be determined under*  
4 *Section 14169.58.*

5 *14169.67. Notwithstanding any other provision of this article,*  
6 *supplemental payments or other payments under this article shall*  
7 *only be required and payable in any quarter for which a fee*  
8 *payment obligation exists.*

9 *14169.68. (a) In order to ensure that the proceeds of the*  
10 *quality assurance fee, the matching amount provided by the federal*  
11 *government, and any interest earned on those proceeds are used*  
12 *to supplement existing funding for hospital services provided to*  
13 *Medi-Cal patients and not supplant such funding, the aggregate*  
14 *fee-for-service payments under the Medi-Cal program to hospitals*  
15 *for hospital services furnished on and after January 1, 2014, for*  
16 *each fiscal year or portion thereof that is in a program period*  
17 *shall not be less than the aggregate amounts that would have been*  
18 *paid for those services under the rates and payment methodologies*  
19 *in effect on December 31, 2013. This provision shall be applied*  
20 *separately for each category of hospital services.*

21 *(b) For purposes of this section, all of the following definitions*  
22 *shall apply:*

23 *(1) "Aggregate amounts" means payments that would have*  
24 *been made on a fee-for-service basis to a hospital under Medi-Cal*  
25 *where the nonfederal share of the payments would have been*  
26 *appropriated from state general funds with the exception of*  
27 *disproportionate share replacement payments made under Section*  
28 *14166.11. Aggregate amounts do not include payments made*  
29 *pursuant to Article 5.228 (commencing with Section 14169.1).*

30 *(2) "Aggregate fee-for-service payments" means all payments*  
31 *made on a fee-for-service basis to a hospital under Medi-Cal where*  
32 *the nonfederal share of the payments were appropriated from state*  
33 *general funds with the exception of disproportionate share*  
34 *replacement payments made under Section 14166.11. Aggregate*  
35 *fee-for-service payments do not include payments made under this*  
36 *article.*

37 *(3) "Hospital services" means all services covered under*  
38 *Medi-Cal furnished by a hospital, including, but not limited to,*  
39 *hospital inpatient services, hospital outpatient services, skilled*

1 *nursing facility services furnished by a hospital, and subacute*  
2 *services furnished by a hospital.*

3 *(c) Disproportionate share replacement payments to private*  
4 *hospitals shall be not less than the amount determined pursuant*  
5 *to Section 14166.11. For purposes of this subdivision, references*  
6 *to Section 14166.11 are to the version of Section 14166.11 in effect*  
7 *on the effective date of this article.*

8 *(d) This section shall be implemented only to the extent it does*  
9 *not violate federal law and only to the extent available federal*  
10 *financial participation is not jeopardized.*

11 *(e) This section shall not require a rate or level of funding to*  
12 *be maintained where federal financial participation for the rate*  
13 *or level of funding has been reduced or eliminated by federal law.*

14 *14169.69. (a) The director shall do all of the following:*

15 *(1) Promptly submit any state plan amendment or waiver request*  
16 *that may be necessary to implement this article.*

17 *(2) Promptly seek federal approvals or waivers as may be*  
18 *necessary to implement this article and to obtain federal financial*  
19 *participation to the maximum extent possible for the payments*  
20 *under this article.*

21 *(3) Amend the contracts between the managed health care plans*  
22 *and the department as necessary to incorporate the provisions of*  
23 *Sections 14169.56 and 14169.57 and promptly seek all necessary*  
24 *federal approvals of those amendments. The department shall*  
25 *pursue amendments to the contracts as soon as possible after the*  
26 *effective date of this article, and shall not wait for federal approval*  
27 *of this article prior to pursuing amendments to the contracts. The*  
28 *amendments to the contracts shall, among other provisions, set*  
29 *forth an agreement to increase capitation payments to managed*  
30 *health care plans under Section 14169.56 and increase payments*  
31 *to hospitals under Section 14169.57 in a manner that relates back*  
32 *to the beginning of a program period, or as soon thereafter as*  
33 *possible, conditioned on obtaining all federal approvals necessary*  
34 *for federal financial participation for the increased capitation*  
35 *payments to the managed health care plans.*

36 *(b) In implementing this article, the department may utilize the*  
37 *services of the Medi-Cal fiscal intermediary through a change*  
38 *order to the fiscal intermediary contract to administer this*  
39 *program, consistent with the requirements of Sections 14104.6,*  
40 *14104.7, 14104.8, and 14104.9. Contracts entered into for purposes*



1 of implementing this article shall not be subject to Part 2  
2 (commencing with Section 10100) of Division 2 of the Public  
3 Contract Code.

4 (c) In the event any hospital, or any party on behalf of a hospital,  
5 initiates a case or proceeding in any state or federal court in which  
6 the hospital seeks any relief of any sort whatsoever, including, but  
7 not limited to, monetary relief, injunctive relief, declaratory relief,  
8 or a writ, based in whole or in part on a contention that any or all  
9 of this article is unlawful and may not be lawfully implemented,  
10 both of the following shall apply:

11 (1) Payments shall not be made to the hospital pursuant to this  
12 article until the case or proceeding is finally resolved, including  
13 the final disposition of all appeals.

14 (2) Any amount computed to be payable to the hospital pursuant  
15 to this article for a subject fiscal year shall be withheld by the  
16 department and shall be paid to the hospital only after the case or  
17 proceeding is finally resolved, including the final disposition of  
18 all appeals.

19 (d) Subject to Section 14169.63, no payment shall be made  
20 under this article until all necessary federal approvals for the  
21 payment and for the fee provisions in this article have been  
22 obtained and the fee has been imposed and collected.  
23 Notwithstanding any other law, payments under this article shall  
24 be made only to the extent that the fee established in this article  
25 is collected and available to cover the nonfederal share of the  
26 payments.

27 (e) All payments made by the department to hospitals and  
28 managed health care plans under this article shall be made only  
29 from the following:

30 (1) The quality assurance fee set forth in this article, along with  
31 any interest or other investment income thereon.

32 (2) Federal reimbursement and any other related federal funds.

33 (f) In order to ensure access to care to hospital services, the  
34 director shall seek federal approval for supplemental payments  
35 for hospital services provided to all Medi-Cal populations,  
36 including the optional and expansion populations.

37 14169.70. Notwithstanding Chapter 3.5 (commencing with  
38 Section 11340) of Part 1 of Division 3 of Title 2 of the Government  
39 Code, the department may implement this article by means of  
40 provider bulletins, all plan letters, or other similar instruction,

1 without taking regulatory action. The department shall also provide  
2 notification to the Joint Legislative Budget Committee and to the  
3 fiscal and appropriate policy committees of the Legislature within  
4 five working days when the above-described action is taken in  
5 order to inform the Legislature that the action is being  
6 implemented.

7 14169.71. Notwithstanding any other provision of this article,  
8 the director may proportionately reduce the amount of any  
9 supplemental payments or increased capitation payments under  
10 this article to the extent that the payment would result in the  
11 reduction of other amounts payable to a hospital or managed  
12 health care plan due to the application of federal law.

13 14169.72. This article shall become inoperative if any of the  
14 following occurs:

15 (a) The effective date of a final judicial determination made by  
16 any court of appellate jurisdiction or a final determination by the  
17 United States Department of Health and Human Services or the  
18 federal Centers for Medicare and Medicaid Services that the  
19 quality assurance fee established pursuant to this article, or Section  
20 14169.54 or 14169.55, cannot be implemented. This subdivision  
21 shall not apply to any final judicial determination made by any  
22 court of appellate jurisdiction in a case brought by hospitals  
23 located outside the state.

24 (b) The federal Centers for Medicare and Medicaid Services  
25 denies approval for, or does not approve on or before the last day  
26 of a program period, the implementation of Sections 14169.52,  
27 14169.53, 14169.54, and 14169.55, and the department fails to  
28 modify Section 14169.52, 14169.53, 14169.54, or 14169.55  
29 pursuant to subdivision (d) of Section 14169.53 in order to meet  
30 the requirements of federal law or to obtain federal approval.

31 (c) A final judicial determination by the California Supreme  
32 Court or any California Court of Appeal that the revenues collected  
33 pursuant to this article that are deposited in the Hospital Quality  
34 Assurance Revenue Fund are either of the following:

35 (1) "General Fund proceeds of taxes appropriated pursuant to  
36 Article XIII B of the California Constitution," as used in  
37 subdivision (b) of Section 8 of Article XVI of the California  
38 Constitution.

39 (2) "Allocated local proceeds of taxes," as used in subdivision  
40 (b) of Section 8 of Article XVI of the California Constitution.

1     (d) The department has sought but has not received federal  
2     financial participation for the supplemental payments and other  
3     costs required by this article for which federal financial  
4     participation has been sought.

5     (e) A lawsuit related to this article is filed against the state and  
6     a preliminary injunction or other order has been issued that results  
7     in a financial disadvantage to the state. For purposes of this  
8     subdivision, “financial disadvantage to the state” means either of  
9     the following:

10    (1) A loss of federal financial participation.

11    (2) A cost to the General Fund that is equal to or greater than  
12    one-quarter of 1 percent of the General Fund expenditures  
13    authorized in the most recent annual Budget Act.

14    (f) The proceeds of the fee and any interest and dividends earned  
15    on deposits are not deposited into the Hospital Quality Assurance  
16    Revenue Fund or are not used as provided in section 14169.53.

17    (g) The proceeds of the fee, the matching amount provided by  
18    the federal government, and interest and dividends earned on  
19    deposits in the Hospital Quality Assurance Revenue Fund are not  
20    used as provided in section 14169.68.

21    14169.73. In the event this article becomes inoperative pursuant  
22    to Section 14169.72, all of the following shall apply:

23    (a) No hospital shall be required to pay the fee except for any  
24    fee owed prior to the article becoming inoperative.

25    (b) The director shall execute a declaration stating that he or  
26    she has determined that the article is inoperative and shall state  
27    the basis for this determination. The director shall retain the  
28    declaration and provide a copy, within five working days of the  
29    execution of the declaration, to the fiscal and appropriate policy  
30    committees of the Legislature. In addition, the director shall post  
31    the declaration on the department’s Internet Web site and the  
32    director shall send the declaration to the Secretary of State, the  
33    Secretary of the Senate, the Chief Clerk of the Assembly, and the  
34    Legislative Counsel.

35    (c) Upon execution of the declaration described in subdivision  
36    (b), the director shall implement a plan, in consultation with the  
37    hospital community and the Legislature, to wind down the program  
38    consistent with the purposes of the article, including the  
39    recoupment of payments made under this article if ordered by a  
40    court.

1     14169.74. *Beginning with the proposed budget for the 2014–15*  
2 *fiscal year, and each fiscal year thereafter, the Department of*  
3 *Finance shall report in the Governor’s proposed budget and the*  
4 *May Revision the difference in General Fund benefit for the*  
5 *upcoming fiscal year resulting from this article and what was*  
6 *anticipated at the time the Budget Act of 2013 was enacted. It is*  
7 *the intent of the Legislature that additional General Fund benefit*  
8 *be appropriated to supplement, and not supplant, funding for*  
9 *health and human service programs, which may include the cost*  
10 *of medical interpreters.*

11     14169.75. *Notwithstanding Section 14169.72, this article shall*  
12 *become inoperative on January 1, 2017. No hospital shall be*  
13 *required to pay the fee after that date unless the fee was owed*  
14 *during the period in which the article was operative, and no*  
15 *payments authorized under Section 14169.53 shall be made unless*  
16 *the payments were owed during the period in which the article*  
17 *was operative.*

18     14169.76. *This article is repealed on January 1 of the year*  
19 *following the date on which the article becomes inoperative.*

20     SEC. 7. *Article 5.231 (commencing with Section 14169.81) is*  
21 *added to Chapter 7 of Part 3 of Division 9 of the Welfare and*  
22 *Institutions Code, to read:*

23  
24     Article 5.231. *Medi-Cal Hospital Reimbursement Improvement*  
25                     *and Restoration Act of 2013*  
26

27     14169.81. (a) *Notwithstanding Sections 14105.191 and*  
28 *14105.192, reimbursement for services provided by skilled nursing*  
29 *facilities that are distinct parts of general acute care hospitals*  
30 *shall be determined, for dates of service on or after October 1,*  
31 *2013, without application of the reductions and limitations set*  
32 *forth in Sections 14105.191 and 14105.192.*

33     (b) *The director shall promptly seek all necessary federal*  
34 *approvals to implement this section.*

35     (c) *Notwithstanding Chapter 3.5 (commencing with Section*  
36 *11340) of Part 1 of Division 3 of Title 2 of the Government Code,*  
37 *the department may implement this section by means of provider*  
38 *bulletins or notices, policy letters, or other similar instructions,*  
39 *without taking regulatory action.*

14169.82. (a) In consultation with the hospital community, as defined in Section 14169.51, the department shall develop proposed modifications to the quality assurance fee program under Article 5.230 (commencing with Section 14169.50) to collect additional fees solely designated for use under this section. In addition, the department shall consult with the hospital community to enable intergovernmental transfers from nondesignated public hospitals solely designated for use under this section. The department shall notify the Joint Legislative Budget Committee and fiscal and appropriate policy committees 30 working days prior to implementing a modification pursuant to this section.

(b) To the extent federal financial participation is not jeopardized and consistent with federal law, and subject to the conditions set forth in subdivision (c), the department shall pay Medi-Cal managed care plans rate range increases, as defined by paragraph (4) of subdivision (b) of Section 14301.4, for the purpose of increasing payments to private hospitals and nondesignated public hospitals in counties that do not have designated public hospitals. Nondesignated public hospitals shall be given priority relative to accessing rate range funds in counties where a nondesignated public hospital is the only public hospital.

(c) Payments to Medi-Cal managed care plans pursuant to subdivision (b) are conditioned on both of the following:

(A) The Medi-Cal managed care plan shall pay all of the rate range increases provided under this section as additional payments to private hospitals and nondesignated public hospitals for providing and making available services to Medi-Cal enrollees of the plan.

(B) The amount of the increases to Medi-Cal managed care plans shall be limited to the total amount of payments possible, including federal financial participation, based on the amount of fees actually collected and intergovernmental transfers actually provided pursuant to subdivision (a) as the nonfederal share for these payments.

14169.83. To the extent permitted by federal law and other federal requirements, the director shall develop and describe in provider bulletins and on the department's Internet Web site a process by which a private general acute care hospital located outside the state that serves Medi-Cal beneficiaries may opt in to pay the quality assurance fee on all applicable categories of patient

1 days and receive supplemental payments for the Medi-Cal program  
2 patient days pursuant to Article 5.230 (commencing with Section  
3 14169.50), in the same manner that the hospital could participate  
4 if it were located in the state. Notwithstanding Section 14169.51,  
5 the department shall rely on reliable data to make reasonable  
6 estimates or projections made with respect to the hospital as to  
7 the data, including, but not limited to, the days data source, used  
8 for the following: acute psychiatric days, annual fee-for-service  
9 days, annual managed care days, annual Medi-Cal days,  
10 fee-for-service days, general acute care days, high acuity days,  
11 managed care days, Medi-Cal days, Medi-Cal fee-for-service days,  
12 Medi-Cal managed care days, Medi-Cal managed care fee days,  
13 outpatient base amount, and transplant days, used to calculate the  
14 fees due and the supplemental payments. The director may modify  
15 the procedure set forth in this section to the minimum extent  
16 necessary to comply with applicable law, in consultation with the  
17 hospital community as defined in Section 14169.51.

18 SEC. 8. This act is an urgency statute necessary for the  
19 immediate preservation of the public peace, health, or safety within  
20 the meaning of Article IV of the Constitution and shall go into  
21 immediate effect. The facts constituting the necessity are:

22 In order to make the necessary changes to increase Medi-Cal  
23 payments to hospitals and improve access at the earliest time, so  
24 as to allow this act to be operative as soon as approval from the  
25 federal Centers for Medicare and Medicaid Services is obtained  
26 by the State Department of Health Care Services, it is necessary  
27 that this act takes effect immediately.

28 SECTION 1. ~~The Legislature finds and declares both of the~~  
29 ~~following:~~

30 ~~(a) The Legislature continues to recognize the essential role that~~  
31 ~~hospitals play in serving the state's Medi-Cal beneficiaries. To~~  
32 ~~that end, it has been, and remains, the intent of the Legislature to~~  
33 ~~improve funding for hospitals and obtain all available federal funds~~  
34 ~~to make supplemental Medi-Cal payments to hospitals.~~

35 ~~(b) It is the intent of the Legislature that funding provided to~~  
36 ~~hospitals through a hospital quality assurance fee be explored with~~  
37 ~~the goal of increasing access to care and improving hospital~~  
38 ~~reimbursement through supplemental Medi-Cal payments to~~  
39 ~~hospitals.~~

1 ~~SEC. 2.— (a) It is the intent of the Legislature to impose a quality~~  
2 ~~assurance fee to be paid by hospitals, which would be used to~~  
3 ~~increase federal financial participation in order to make~~  
4 ~~supplemental Medi-Cal payments to hospitals for the period of~~  
5 ~~January 1, 2014, through December 31, 2015, and to help pay for~~  
6 ~~health care coverage for low-income children.~~

7 ~~(b) The State Department of Health Care Services shall make~~  
8 ~~every effort to obtain the necessary federal approvals to implement~~  
9 ~~the quality assurance fee described in subdivision (a) in order to~~  
10 ~~make supplemental Medi-Cal payments to hospitals for the period~~  
11 ~~of January 1, 2014, through December 31, 2015.~~

12 ~~(c) It is the intent of the Legislature that the quality assurance~~  
13 ~~fee be implemented only if all of the following conditions are met:~~

14 ~~(1) The quality assurance fee is established in consultation with~~  
15 ~~the hospital community.~~

16 ~~(2) The quality assurance fee, including any interest earned after~~  
17 ~~collection by the department, is deposited into segregated funds~~  
18 ~~apart from the General Fund and used exclusively for supplemental~~  
19 ~~Medi-Cal payments to hospitals, direct grants to public hospitals,~~  
20 ~~health care coverage for low-income children, and for the direct~~  
21 ~~costs of administering the program by the department.~~

22 ~~(3) No hospital shall be required to pay the quality assurance~~  
23 ~~fee to the department unless and until the state receives and~~  
24 ~~maintains federal approval of the quality assurance fee and related~~  
25 ~~supplemental payments to hospitals.~~

26 ~~(4) The full amount of the quality assurance fee assessed and~~  
27 ~~collected remains available only for the purposes specified by the~~  
28 ~~Legislature in this act.~~

29 ~~SEC. 3.— Section 14164 of the Welfare and Institutions Code is~~  
30 ~~amended to read:~~

31 ~~14164.— (a) In addition to the required intergovernmental~~  
32 ~~transfers set forth in Section 14163, any county, other political~~  
33 ~~subdivision of the state, or governmental entity in the state may~~  
34 ~~elect to transfer funds, subject to subdivision (m) of Section 14163,~~  
35 ~~to the department in support of the Medi-Cal program. Those~~  
36 ~~transfers may consist of cash or loans to the state. The department~~  
37 ~~shall have the discretion to accept or not accept any elective transfer~~  
38 ~~from a county, political subdivision, or other governmental entity,~~  
39 ~~as well as the discretion of whether to deposit the transfer in the~~  
40 ~~Medi-Cal Inpatient Payment Adjustment Fund established pursuant~~

1 to Section 14163. If the department accepts a transfer pursuant to  
2 this section, the department shall obtain federal matching funds to  
3 the full extent permitted by federal law.

4 (b) (1) The director may maximize available federal financial  
5 participation to provide access to services provided by hospitals  
6 that are not reimbursed by certified public expenditure pursuant  
7 to Article 5.2 (commencing with Section 14166) by authorizing  
8 the use of intergovernmental transfers to fund the nonfederal share  
9 of supplemental payments as permitted under Section 433.51 of  
10 Title 42 of the Code of Federal Regulations or any other applicable  
11 federal Medicaid laws. The transferring entity shall certify to the  
12 department that the funds are in compliance with all federal rules  
13 and regulations. Any payments funded by intergovernmental  
14 transfers shall remain with the hospital and shall not be transferred  
15 back to any county, other political subdivision of the state, or  
16 governmental entity in the state, except for federal disallowance  
17 or withhold recovery efforts by the department. Participation in  
18 intergovernmental transfers under this subdivision is voluntary on  
19 the part of the transferring entity for purposes of all applicable  
20 federal laws.

21 (2) This subdivision shall be implemented only to the extent  
22 federal financial participation is not jeopardized.

23 SEC. 4. Section 14165 of the Welfare and Institutions Code is  
24 amended to read:

25 14165. (a) There is hereby created in the Governor's office  
26 the California Medical Assistance Commission, for the purpose  
27 of contracting with health care delivery systems for the provision  
28 of health care services to recipients under the California Medical  
29 Assistance Program.

30 (b) Notwithstanding any other law, the commission created  
31 pursuant to subdivision (a) shall continue through June 30, 2012,  
32 after which, it shall be dissolved and the term of any commissioner  
33 serving at that time shall end.

34 (1) Upon dissolution of the commission, all powers, duties, and  
35 responsibilities of the commission shall be transferred to the  
36 Director of Health Care Services. These powers, duties, and  
37 responsibilities shall include, but are not limited to, those exercised  
38 in the operation of the selective provider contracting program  
39 pursuant to Article 2.6 (commencing with Section 14081).



1     ~~(2) (A) On July 1, 2012, notwithstanding any other law,~~  
2     ~~employees of the California Medical Assistance Commission as~~  
3     ~~of June 30, 2012, excluding commissioners, shall transfer to the~~  
4     ~~State Department of Health Care Services.~~

5     ~~(B) Employees who transfer pursuant to subparagraph (A) shall~~  
6     ~~be subject to the same conditions of employment under the~~  
7     ~~department as they were under the California Medical Assistance~~  
8     ~~Commission, including retention of their exempt status, until the~~  
9     ~~diagnosis-related groups payment system described in Section~~  
10    ~~14105.28 replaces the contract-based payment system described~~  
11    ~~in this article.~~

12    ~~(C) (i) Notwithstanding any other law or rule, persons employed~~  
13    ~~by the department who transferred to the department pursuant to~~  
14    ~~subparagraph (A) shall be eligible to apply for civil service~~  
15    ~~examinations. Persons receiving passing scores shall have their~~  
16    ~~names placed on lists resulting from these examinations, or~~  
17    ~~otherwise gain eligibility for appointment. In evaluating minimum~~  
18    ~~qualifications, related California Medical Assistance Commission~~  
19    ~~experience shall be considered state civil service experience in a~~  
20    ~~class deemed comparable by the State Personnel Board, based on~~  
21    ~~the duties and responsibilities assigned.~~

22    ~~(ii) On the date the diagnosis-related groups payment system~~  
23    ~~described in Section 14105.28 replaces the contract-based system~~  
24    ~~described in this article, employees who transferred to the~~  
25    ~~department pursuant to subparagraph (A) shall transfer to civil~~  
26    ~~service classifications within the department for which they are~~  
27    ~~eligible.~~

28    ~~(3) Upon a determination by the Director of Health Care~~  
29    ~~Services that a payment system based on diagnosis-related groups~~  
30    ~~as described in Section 14105.28 that is sufficient to replace the~~  
31    ~~contract-based payment system described in this article has been~~  
32    ~~developed and implemented, the powers, duties, and responsibilities~~  
33    ~~conferred on the commission and transferred to the Director of~~  
34    ~~Health Care Services shall no longer be exercised, excluding all~~  
35    ~~of the following:~~

36    ~~(A) Stabilization payments made or committed from Sections~~  
37    ~~14166.14 and 14166.19 for services rendered prior to the director's~~  
38    ~~determination pursuant to this paragraph.~~

39    ~~(B) The ability to negotiate and make payments from the Private~~  
40    ~~Hospital Supplemental Fund, established pursuant to Section~~

1 14166.12, and the Nondesignated Public Hospital Supplemental  
2 Fund, established pursuant to Section 14166.17.

3 (C) The ability to continue to administer and distribute payments  
4 for the Construction Renovation Reimbursement Program, in  
5 accordance with Sections 14085 to 14085.57, inclusive.  
6 Notwithstanding any other law, maintaining or negotiating a  
7 selective provider contract pursuant to Article 2.6 (commencing  
8 with Section 14081) or a contract with a county organized health  
9 system shall cease to be a requirement for a hospital's participation  
10 in the Construction Renovation Reimbursement Program.

11 (4) Protections afforded to the negotiations and contracts of the  
12 commission by the California Public Records Act (Chapter 3.5  
13 (commencing with Section 6250) of Division 7 of Title 1 of the  
14 Government Code) shall be applicable to the negotiations and  
15 contracts conducted or entered into pursuant to this section by the  
16 State Department of Health Care Services.

17 (e) Notwithstanding the rulemaking provisions of Chapter 3.5  
18 (commencing with Section 11340) of Part 1 of Division 3 of Title  
19 2 of the Government Code, or any other provision of law, the State  
20 Department of Health Care Services may implement and administer  
21 this section by means of provider bulletins or other similar  
22 instructions, without taking regulatory action. The authority to  
23 implement this section as set forth in this subdivision shall include  
24 the authority to give notice by provider bulletin or other similar  
25 instruction of a determination made pursuant to paragraph (3) of  
26 subdivision (b) and to modify or supersede existing regulations in  
27 Title 22 of the California Code of Regulations that conflict with  
28 implementation of this section.

29 SEC. 5. Section 14167.35 of the Welfare and Institutions Code  
30 is amended to read:

31 14167.35. (a) The Hospital Quality Assurance Revenue Fund  
32 is hereby created in the State Treasury.

33 (b) (1) All fees required to be paid to the state pursuant to this  
34 article shall be paid in the form of remittances payable to the  
35 department.

36 (2) The department shall directly transmit the fee payments to  
37 the Treasurer to be deposited in the Hospital Quality Assurance  
38 Revenue Fund. Notwithstanding Section 16305.7 of the  
39 Government Code, any interest and dividends earned on deposits

1 in the fund shall be retained in the fund for purposes specified in  
2 subdivision (c):

3 ~~(e) All funds in the Hospital Quality Assurance Revenue Fund,~~  
4 ~~together with any interest and dividends earned on money in the~~  
5 ~~fund, shall, upon appropriation by the Legislature, be used~~  
6 ~~exclusively to enhance federal financial participation for hospital~~  
7 ~~services under the Medi-Cal program, to provide additional~~  
8 ~~reimbursement to, and to support quality improvement efforts of,~~  
9 ~~hospitals, and to minimize uncompensated care provided by~~  
10 ~~hospitals to uninsured patients, in the following order of priority:~~

11 ~~(1) To pay for the department's staffing and administrative costs~~  
12 ~~directly attributable to implementing Article 5.21 (commencing~~  
13 ~~with Section 14167.1) and this article, including any administrative~~  
14 ~~fees that the director determines shall be paid to mental health~~  
15 ~~plans pursuant to subdivision (d) of Section 14167.11 and~~  
16 ~~repayment of the loan made to the department from the Private~~  
17 ~~Hospital Supplemental Fund pursuant to the act that added this~~  
18 ~~section.~~

19 ~~(2) To pay for the health care coverage for children in the~~  
20 ~~amount of eighty million dollars (\$80,000,000) for each subject~~  
21 ~~fiscal quarter for which payments are made under Article 5.21~~  
22 ~~(commencing with Section 14167.1).~~

23 ~~(3) To make increased capitation payments to managed health~~  
24 ~~care plans pursuant to Article 5.21 (commencing with Section~~  
25 ~~14167.1).~~

26 ~~(4) To pay funds from the Hospital Quality Assurance Revenue~~  
27 ~~Fund pursuant to Section 14167.5 that would have been used for~~  
28 ~~grant payments and that are retained by the state, and to make~~  
29 ~~increased payments to hospitals, including grants, pursuant to~~  
30 ~~Article 5.21 (commencing with Section 14167.1), both of which~~  
31 ~~shall be of equal priority.~~

32 ~~(5) To make increased payments to mental health plans pursuant~~  
33 ~~to Article 5.21 (commencing with Section 14167.1).~~

34 ~~(d) Any amounts of the quality assurance fee collected in excess~~  
35 ~~of the funds required to implement subdivision (c), including any~~  
36 ~~funds recovered under subdivision (d) of Section 14167.14 or~~  
37 ~~subdivision (e) of Section 14167.36, shall be refunded to general~~  
38 ~~acute care hospitals, pro rata with the amount of quality assurance~~  
39 ~~fee paid by the hospital, subject to the limitations of federal law.~~  
40 ~~If federal rules prohibit the refund described in this subdivision,~~

1 the excess funds shall be deposited in the Distressed Hospital Fund  
2 to be used for the purposes described in Section 14166.23, and  
3 shall be supplemental to and not supplant existing funds.

4 (e) Any methodology or other provision specified in Article  
5 5.21 (commencing with Section 14167.1) and this article may be  
6 modified by the department, in consultation with the hospital  
7 community, to the extent necessary to meet the requirements of  
8 federal law or regulations to obtain federal approval or to enhance  
9 the probability that federal approval can be obtained, provided the  
10 modifications do not violate the spirit and intent of Article 5.21  
11 (commencing with Section 14167.1) or this article and are not  
12 inconsistent with the conditions of implementation set forth in  
13 Section 14167.36.

14 (f) The department, in consultation with the hospital community,  
15 shall make adjustments, as necessary, to the amounts calculated  
16 pursuant to Section 14167.32 in order to ensure compliance with  
17 the federal requirements set forth in Section 433.68 of Title 42 of  
18 the Code of Federal Regulations or elsewhere in federal law.

19 (g) The department shall request approval from the federal  
20 Centers for Medicare and Medicaid Services for the implementation  
21 of this article. In making this request, the department shall seek  
22 specific approval from the federal Centers for Medicare and  
23 Medicaid Services to exempt providers identified in this article as  
24 exempt from the fees specified, including the submission, as may  
25 be necessary, of a request for waiver of the broad-based  
26 requirement, waiver of the uniform fee requirement, or both,  
27 pursuant to paragraphs (e)(1) and (e)(2) of Section 433.68 of Title  
28 42 of the Code of Federal Regulations.

29 (h) (1) For purposes of this section, a modification pursuant to  
30 this section shall be implemented only if the modification, change,  
31 or adjustment does not do either of the following:

32 (A) Reduces or increases the supplemental payments or grants  
33 made under Article 5.21 (commencing with Section 14167.1) in  
34 the aggregate for the 2008–09, 2009–10, and 2010–11 federal  
35 fiscal years to a hospital by more than 2 percent of the amount that  
36 would be determined under this article without any change or  
37 adjustment.

38 (B) Reduces or increases the amount of the fee payable by a  
39 hospital in total under this article for the 2008–09, 2009–10, and  
40 2010–11 federal fiscal years by more than 2 percent of the amount

1 that would be determined under this article without any change or  
2 adjustment.

3 ~~(2) The department shall provide the Joint Legislative Budget~~  
4 ~~Committee and the fiscal and appropriate policy committees of~~  
5 ~~the Legislature a status update of the implementation of Article~~  
6 ~~5.21 (commencing with Section 14167.1) and this article on~~  
7 ~~January 1, 2010, and quarterly thereafter. Information on any~~  
8 ~~adjustments or modifications to the provisions of this article or~~  
9 ~~Article 5.21 (commencing with Section 14167.1) that may be~~  
10 ~~required for federal approval shall be provided coincident with the~~  
11 ~~consultation required under subdivisions (f) and (g).~~

12 ~~(i) Notwithstanding Chapter 3.5 (commencing with Section~~  
13 ~~11340) of Part 1 of Division 3 of Title 2 of the Government Code,~~  
14 ~~the department may implement this article or Article 5.21~~  
15 ~~(commencing with Section 14167.1) by means of provider~~  
16 ~~bulletins, all plan letters, or other similar instruction, without taking~~  
17 ~~regulatory action. The department shall also provide notification~~  
18 ~~to the Joint Legislative Budget Committee and to the appropriate~~  
19 ~~policy and fiscal committees of the Legislature within five working~~  
20 ~~days when the above-described action is taken in order to inform~~  
21 ~~the Legislature that the action is being implemented.~~

22 ~~(j) Notwithstanding any law, the Controller may use the funds~~  
23 ~~in the Hospital Quality Assurance Revenue Fund for cashflow~~  
24 ~~loans to the General Fund as provided in Sections 16310 and 16381~~  
25 ~~of the Government Code.~~

26 ~~(k) Notwithstanding Sections 14167.17 and 14167.40,~~  
27 ~~subdivisions (b) to (h), inclusive, shall become inoperative on~~  
28 ~~January 1, 2013, subdivisions (a), (i), and (j) shall remain operative~~  
29 ~~until January 1, 2017, and as of January 1, 2017, this section is~~  
30 ~~repealed.~~

31 ~~SEC. 6. Section 14167.37 is added to the Welfare and~~  
32 ~~Institutions Code, to read:~~

33 ~~14167.37. (a) (1) The department shall make available all~~  
34 ~~public documentation it uses to administer and audit the program~~  
35 ~~authorized under Article 5.230 (commencing with Section~~  
36 ~~14169.51) and Article 5.231 (commencing with Section 14169.71)~~  
37 ~~pursuant to the Public Records Act (Chapter 3.5 (commencing~~  
38 ~~with Section 6250) of Division 7 of Title 1 of the Government~~  
39 ~~Code).~~

~~(2) In addition, upon request from a hospital, the department shall require Medi-Cal managed care plans to furnish hospitals with the amounts the plan intends to pay to the hospital pursuant to Article 5.230 (commencing with Section 14169.51). Nothing in this paragraph shall require the department to reconcile payments made to individual hospitals from Medi-Cal managed care plans.~~

~~(b) Notwithstanding subdivision (a), the department shall post all of the following on the department's Internet Web site:~~

~~(1) Within 10 business days after receipt of approval of the hospital quality assurance fee program under Article 5.230 (commencing with Section 14169.51) and Article 5.231 (commencing with Section 14169.71) from the federal Centers for Medicare and Medicaid Services (CMS), the hospital quality assurance fee final model and upper payment limit calculations:~~

~~(2) Quarterly updates on payments, fee schedules, and model updates when applicable.~~

~~(3) Within 10 business days after receipt, information on managed care rate approvals.~~

~~(c) For purposes of this section, the following definitions shall apply:~~

~~(1) "Fee schedules" mean the dates on which the hospital quality assurance fee will be due from the hospitals and the dates on which the department will submit fee-for-service payments to the hospitals. "Fee schedules" also include the dates on which the department is expected to submit payments to managed care plans.~~

~~(2) "Hospital quality assurance fee final model" means the spreadsheet calculating the supplemental amounts based on the upper payment limit calculation from claims and hospital data sources of days and hospital services once CMS approves the program under Article 5.230 (commencing with Section 14169.51) and Article 5.231 (commencing with Section 14169.71).~~

~~(3) "Upper payment limit calculation" means the determination of the federal upper payment limit on the amount of the Medicaid payment for which federal financial participation is available for a class of service and a class of health care providers, as specified in Part 447 of Title 42 of the Code of Federal Regulations and that has been approved by CMS.~~

~~SEC. 7. Article 5.230 (commencing with Section 14169.51) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:~~

Article 5.230. Medi-Cal Hospital Reimbursement Improvement  
Act of 2013

14169.51. For purposes of this article, the following definitions shall apply:

(a) “Acute psychiatric days” means the total number of Medi-Cal specialty mental health service administrative days, Medi-Cal specialty mental health service acute care days, acute psychiatric administrative days, and acute psychiatric acute days identified in the Final Medi-Cal Utilization Statistics for the 2012–13 state fiscal year as calculated by the department as of December 17, 2012.

(b) “Converted hospital” means a private hospital that becomes a designated public hospital or a nondesignated public hospital on or after January 1, 2014.

(c) “Days data source” means the hospital’s Annual Financial Disclosure Report filed with the Office of Statewide Health Planning and Development as of June 6, 2013, for its fiscal year ending during 2010.

(d) “Department” means the State Department of Health Care Services.

(e) “Designated public hospital” shall have the meaning given in subdivision (d) of Section 14166.1.

(f) “Director” means the Director of Health Care Services.

(g) “General acute care days” means the total number of Medi-Cal general acute care days, including well baby days, less any acute psychiatric inpatient days, paid by the department to a hospital for services in the 2010 calendar year, as reflected in the state paid claims file on April 26, 2013.

(h) “High acuity days” means Medi-Cal coronary care unit days, pediatric intensive care unit days, intensive care unit days, neonatal intensive care unit days, and burn unit days paid by the department during the 2010 calendar year, as reflected in the state paid claims file prepared by the department on April 26, 2013.

(i) “Hospital community” means any general acute care hospital and any hospital industry organization that represents general acute care hospitals.

(j) “Hospital inpatient services” means all services covered under Medi-Cal and furnished by hospitals to patients who are admitted as hospital inpatients and reimbursed on a fee-for-service

1 basis by the department directly or through its fiscal intermediary.  
2 Hospital inpatient services include outpatient services furnished  
3 by a hospital to a patient who is admitted to that hospital within  
4 24 hours of the provision of the outpatient services that are related  
5 to the condition for which the patient is admitted. Hospital inpatient  
6 services do not include services for which a managed health care  
7 plan is financially responsible.

8 (k) “Hospital outpatient services” means all services covered  
9 under Medi-Cal furnished by hospitals to patients who are  
10 registered as hospital outpatients and reimbursed by the department  
11 on a fee-for-service basis directly or through its fiscal intermediary.  
12 Hospital outpatient services do not include services for which a  
13 managed health care plan is financially responsible, or services  
14 rendered by a hospital-based federally qualified health center for  
15 which reimbursement is received pursuant to Section 14132.100.

16 (l) (1) “Managed health care plan” means a health care delivery  
17 system that manages the provision of health care and receives  
18 prepaid capitated payments from the state in return for providing  
19 services to Medi-Cal beneficiaries.

20 (2) (A) Managed health care plans include county organized  
21 health systems and entities contracting with the department to  
22 provide services pursuant to two-plan models and geographic  
23 managed care. Entities providing these services contract with the  
24 department pursuant to any of the following:

25 (i) Article 2.7 (commencing with Section 14087.3).

26 (ii) Article 2.8 (commencing with Section 14087.5).

27 (iii) Article 2.81 (commencing with Section 14087.96).

28 (iv) Article 2.82 (commencing with Section 14087.98).

29 (v) Article 2.91 (commencing with Section 14089).

30 (B) Managed health care plans do not include any of the  
31 following:

32 (i) Mental health plans contracting to provide mental health care  
33 for Medi-Cal beneficiaries pursuant to Chapter 8.9 (commencing  
34 with Section 14700).

35 (ii) Health plans not covering inpatient services such as primary  
36 care case management plans operating pursuant to Section  
37 14088.85.

38 (iii) Program for All-Inclusive Care for the Elderly organizations  
39 operating pursuant to Chapter 8.75 (commencing with Section  
40 14591).



1     (m) ~~“Medi-Cal managed care days” means the total number of~~  
2     ~~general acute care days, including well baby days, listed for the~~  
3     ~~county organized health system and prepaid health plans identified~~  
4     ~~in the Final Medi-Cal Utilization Statistics for the 2012–13 fiscal~~  
5     ~~year, as calculated by the department as of December 17, 2012.~~

6     (n) ~~“Medicaid inpatient utilization rate” means Medicaid~~  
7     ~~inpatient utilization rate as defined in Section 1396r-4 of Title 42~~  
8     ~~of the United States Code and as set forth in the Final Medi-Cal~~  
9     ~~Utilization Statistics for the 2012–13 fiscal year, as calculated by~~  
10    ~~the department as of December 17, 2012.~~

11    (o) ~~“New hospital” means a hospital operation, business, or~~  
12    ~~facility functioning under current or prior ownership as a private~~  
13    ~~hospital that does not have a days data source or a hospital that~~  
14    ~~has a days data source in whole, or in part, from a previous operator~~  
15    ~~where there is an outstanding monetary obligation owed to the~~  
16    ~~state in connection with the Medi-Cal program and the hospital is~~  
17    ~~not, or does not agree to become, financially responsible to the~~  
18    ~~department for the outstanding monetary obligation in accordance~~  
19    ~~with subdivision (d) of Section 14169.58.~~

20    (p) ~~“Nondesignated public hospital” means either of the~~  
21    ~~following:~~

22    (1) ~~A public hospital that is licensed under subdivision (a) of~~  
23    ~~Section 1250 of the Health and Safety Code, is not designated as~~  
24    ~~a specialty hospital in the hospital’s most recently filed Annual~~  
25    ~~Financial Disclosure Report as of January 1, 2014, and satisfies~~  
26    ~~the definition in paragraph (25) of subdivision (a) of Section~~  
27    ~~14105.98, excluding designated public hospitals.~~

28    (2) ~~A tax-exempt nonprofit hospital that is licensed under~~  
29    ~~subdivision (a) of Section 1250 of the Health and Safety Code, is~~  
30    ~~not designated as a specialty hospital in the hospital’s most recently~~  
31    ~~filed Annual Financial Disclosure Report as of January 1, 2014,~~  
32    ~~is operating a hospital owned by a local health care district, and~~  
33    ~~is affiliated with the health care district hospital owner by means~~  
34    ~~of the district’s status as the nonprofit corporation’s sole corporate~~  
35    ~~member.~~

36    (q) ~~“Outpatient base amount” means the total amount of~~  
37    ~~payments for hospital outpatient services made to a hospital in the~~  
38    ~~2010 calendar year, as reflected in the state paid claims file~~  
39    ~~prepared by the department on April 26, 2013.~~

1     ~~(r) “Private hospital” means a hospital that meets all of the~~  
2     ~~following conditions:~~

3     ~~(1) Is licensed pursuant to subdivision (a) of Section 1250 of~~  
4     ~~the Health and Safety Code.~~

5     ~~(2) Is in the Charitable Research Hospital peer group, as set~~  
6     ~~forth in the 1991 Hospital Peer Grouping Report published by the~~  
7     ~~department, or is not designated as a specialty hospital in the~~  
8     ~~hospital’s most recently filed Office of Statewide Health Planning~~  
9     ~~and Development Annual Financial Disclosure Report as of January~~  
10    ~~1, 2014.~~

11    ~~(3) Does not satisfy the Medicare criteria to be classified as a~~  
12    ~~long-term care hospital.~~

13    ~~(4) Is a nonpublic hospital, nonpublic converted hospital, or~~  
14    ~~converted hospital as those terms are defined in paragraphs (26)~~  
15    ~~to (28), inclusive, respectively, of subdivision (a) of Section~~  
16    ~~14105.98.~~

17    ~~(5) Is not a nondesignated public hospital or a designated public~~  
18    ~~hospital.~~

19    ~~(s) “Program period” means the period from January 1, 2014,~~  
20    ~~to December 31, 2015, inclusive.~~

21    ~~(t) “Subject fiscal quarter” means a state fiscal quarter beginning~~  
22    ~~on or after January 1, 2014, and ending before January 1, 2016.~~

23    ~~(u) “Subject fiscal year” means a state fiscal year that ends after~~  
24    ~~January 1, 2014, and begins before January 1, 2016.~~

25    ~~(v) “Subject month” means a calendar month beginning on or~~  
26    ~~after January 1, 2014, and ending before January 1, 2016.~~

27    ~~(w) “Transplant days” means the number of Medi-Cal days, as~~  
28    ~~defined in subdivision (q) of Section 14169.71, for MS-DRGs 1,~~  
29    ~~2, 5 to 10, inclusive, 14, 15, and 652, according to the 2010 Patient~~  
30    ~~Discharge file from the Office of Statewide Health Planning and~~  
31    ~~Development accessed on June 28, 2011.~~

32    ~~(x) “Upper payment limit” means a federal upper payment limit~~  
33    ~~on the amount of the Medicaid payment for which federal financial~~  
34    ~~participation is available for a class of service and a class of health~~  
35    ~~care providers, as specified in Part 447 of Title 42 of the Code of~~  
36    ~~Federal Regulations. The applicable upper payment limit shall be~~  
37    ~~separately calculated for inpatient and outpatient hospital services.~~

38    ~~14169.52. (a) Private hospitals shall be paid supplemental~~  
39    ~~amounts for the provision of hospital outpatient services for each~~  
40    ~~subject fiscal quarter as set forth in this section. The supplemental~~

1 amounts shall be in addition to any other amounts payable to  
2 hospitals with respect to those services and shall not affect any  
3 other payments to hospitals. The supplemental amounts shall result  
4 in payments equal to the statewide aggregate upper payment limit  
5 for private hospitals for each subject fiscal year, except that with  
6 respect to a subject fiscal year that begins before the start of the  
7 program period or that ends after the end of the program period,  
8 the outpatient supplemental amounts shall result in payments to  
9 hospitals that equal a percentage of the applicable upper payment  
10 limit where the percentage equals the percentage of the subject  
11 fiscal year that occurs during the program period.

12 (b) Except as set forth in subdivisions (e) and (f), each private  
13 hospital shall be paid an amount for each subject fiscal year equal  
14 to a percentage of the hospital's outpatient base amount, which  
15 payments shall be made on a quarterly basis. The percentage shall  
16 be the same for each hospital for a subject fiscal year, or portion  
17 thereof in the program period. The percentage shall result in  
18 payments to hospitals that equal the applicable federal upper  
19 payment limit as it may be modified pursuant to Section 14169.68  
20 for a subject fiscal year, or any portion thereof in the program  
21 period. For purposes of this subdivision the applicable federal  
22 upper payment limit shall be the federal upper payment limit for  
23 hospital outpatient services furnished by private hospitals for each  
24 subject fiscal year, or portion thereof.

25 (c) In the event federal financial participation for a subject fiscal  
26 year is not available for all of the supplemental amounts payable  
27 to private hospitals under subdivision (b) due to the application of  
28 a federal upper payment limit or for any other reason, both of the  
29 following shall apply:

30 (1) The total amount payable to private hospitals under  
31 subdivision (b) for the subject fiscal year shall be reduced to the  
32 amount for which federal financial participation is available.

33 (2) The amount payable under subdivision (b) to each private  
34 hospital for the subject fiscal year shall be equal to the amount  
35 computed under subdivision (b) multiplied by the ratio of the total  
36 amount for which federal financial participation is available to the  
37 total amount computed under subdivision (b).

38 (d) The supplemental amounts set forth in this section are  
39 inclusive of federal financial participation.

1 ~~(e) Payments shall not be made under this section to a new~~  
2 ~~hospital for the periods when the hospital is a new hospital.~~

3 ~~(f) Payments shall be made to a converted hospital that converts~~  
4 ~~during a subject fiscal quarter by multiplying the hospital's~~  
5 ~~outpatient supplemental payment as calculated in subdivision (b)~~  
6 ~~by the number of days that the hospital was a private hospital in~~  
7 ~~the subject fiscal quarter, divided by the number of days in the~~  
8 ~~subject fiscal quarter. Payments shall not be made to a converted~~  
9 ~~hospital in any subsequent subject fiscal quarter.~~

10 ~~14169.53. (a) Except as provided in Section 14169.68, private~~  
11 ~~hospitals shall be paid supplemental amounts for the provision of~~  
12 ~~hospital inpatient services for each subject fiscal quarter as set~~  
13 ~~forth in this section. The supplemental amounts shall be in addition~~  
14 ~~to any other amounts payable to hospitals with respect to those~~  
15 ~~services and shall not affect any other payments to hospitals. The~~  
16 ~~supplemental amounts shall result in payments equal to the~~  
17 ~~statewide aggregate upper payment limit for private hospitals for~~  
18 ~~each subject fiscal year as it may be modified pursuant to Section~~  
19 ~~14169.68, except that with respect to a subject fiscal year that~~  
20 ~~begins before the start of the program period or that ends after the~~  
21 ~~end of the program period, the inpatient supplemental amounts~~  
22 ~~shall result in payments to hospitals that equal a percentage of the~~  
23 ~~applicable upper payment limit where the percentage equals the~~  
24 ~~percentage of the subject fiscal year that occurs during the program~~  
25 ~~period.~~

26 ~~(b) Except as set forth in subdivisions (f) and (g), each private~~  
27 ~~hospital shall be paid the sum of all of the following amounts as~~  
28 ~~applicable for the provision of hospital inpatient services for each~~  
29 ~~subject fiscal quarter:~~

30 ~~(1) One thousand two dollars (\$1,002) multiplied by the~~  
31 ~~hospital's general acute care days for supplemental payments for~~  
32 ~~the 2014 calendar year, divided by four, and one thousand two~~  
33 ~~hundred five dollars (\$1,205) multiplied by the hospital's general~~  
34 ~~acute care days for supplemental payments for the 2015 calendar~~  
35 ~~year, divided by four.~~

36 ~~(2) Nine hundred seventy dollars (\$970) multiplied by the~~  
37 ~~hospital's acute psychiatric days for supplemental payments for~~  
38 ~~the 2014 calendar year, divided by four, and nine hundred~~  
39 ~~seventy-five dollars (\$975) multiplied by the hospital's acute~~

1 psychiatric days for supplemental payments for the 2015 calendar  
2 year, divided by four.

3 ~~(3) Two thousand five hundred dollars (\$2,500) multiplied by~~  
4 ~~the number of the hospital's high acuity days for the respective~~  
5 ~~calendar year for 2014 or 2015, divided by four, if the hospital's~~  
6 ~~Medicaid inpatient utilization rate is less than 43 percent and~~  
7 ~~greater than 5 percent and at least 5 percent of the hospital's general~~  
8 ~~acute care days are high acuity days.~~

9 ~~(4) Two thousand five hundred dollars (\$2,500) multiplied by~~  
10 ~~the number of the hospital's high acuity days for the respective~~  
11 ~~calendar year for 2014 and 2015, divided by four, if the hospital~~  
12 ~~qualifies to receive the amount set forth in paragraph (3) and has~~  
13 ~~been designated as a Level I, Level II, Adult/Ped Level I, or~~  
14 ~~Adult/Ped Level II trauma center by the Emergency Medical~~  
15 ~~Services Authority established pursuant to Section 1797.1 of the~~  
16 ~~Health and Safety Code.~~

17 ~~(5) Two thousand five hundred dollars (\$2,500) multiplied by~~  
18 ~~the number of the hospital's transplant days for the respective~~  
19 ~~calendar year for 2014 and 2015, divided by four, if the hospital's~~  
20 ~~Medicaid inpatient utilization rate is less than 43 percent and~~  
21 ~~greater than 5 percent.~~

22 ~~(6) A payment for hospital inpatient services for private hospitals~~  
23 ~~that provided Medi-Cal subacute services during the 2010 calendar~~  
24 ~~year and have a Medicaid inpatient utilization rate that is greater~~  
25 ~~than 5 percent and less than 43 percent equal to 55 percent for the~~  
26 ~~2014 calendar year of the Medi-Cal subacute payments paid by~~  
27 ~~the department to the hospital during the 2010 calendar year, as~~  
28 ~~reflected in the state paid claims file prepared by the department~~  
29 ~~on April 26, 2013, divided by four, and 60 percent for the 2015~~  
30 ~~calendar year of the Medi-Cal subacute payments paid by the~~  
31 ~~department to the hospital during the 2010 calendar year, as~~  
32 ~~reflected in the state paid claims file prepared by the department~~  
33 ~~on April 26, 2013, divided by four.~~

34 ~~(e) If federal financial participation for a subject fiscal year is~~  
35 ~~not available for all of the supplemental amounts payable to private~~  
36 ~~hospitals under subdivision (b) due to the application of a federal~~  
37 ~~upper payment limit or for any other reason, both of the following~~  
38 ~~shall apply:~~

~~(1) The total amount payable to private hospitals under subdivision (b) for the subject fiscal year shall be reduced to reflect the amount for which federal financial participation is available.~~

~~(2) The amount payable under subdivision (b) to each private hospital for the subject fiscal year shall be equal to the amount computed under subdivision (b) multiplied by the ratio of the total amount for which federal financial participation is available to the total amount computed under subdivision (b).~~

~~(d) If the amount otherwise payable to a hospital under this section for a subject fiscal year exceeds the amount for which federal financial participation is available for that hospital, the amount due to the hospital for that subject fiscal year shall be reduced to the amount for which federal financial participation is available.~~

~~(e) The amounts set forth in this section are inclusive of federal financial participation.~~

~~(f) Payments shall not be made under this section to a new hospital for the periods when the hospital is a new hospital.~~

~~(g) Payments shall be made to a converted hospital that converts during a subject fiscal quarter by multiplying the hospital's inpatient supplemental payment as calculated in subdivision (b) by the number of days that the hospital was a private hospital in the subject fiscal quarter, divided by the number of days in the subject fiscal quarter. Payments shall not be made to a converted hospital in any subsequent subject fiscal quarter.~~

~~14169.54. (a) The department shall increase capitation payments to Medi-Cal managed health care plans for each subject month as set forth in this section.~~

~~(b) The increased capitation payments shall be made as part of the monthly capitated payments made by the department to managed health care plans.~~

~~(c) The aggregate amount of increased capitation payments to all Medi-Cal managed health care plans for each subject fiscal year, or portion thereof in the program period, shall be the maximum amount for which federal financial participation is available on an aggregate statewide basis for the applicable subject fiscal year, or portion thereof in the program period.~~

~~(d) The department shall determine the amount of the increased capitation payments for each managed health care plan. The department shall consider the composition of Medi-Cal enrollees~~

1 in the plan, the anticipated utilization of hospital services by the  
2 plan's Medi-Cal enrollees, and other factors that the department  
3 determines are reasonable and appropriate to ensure access to  
4 high-quality hospital services by the plan's enrollees.

5 (e) ~~The amount of increased capitation payments to each~~  
6 ~~Medi-Cal managed health care plan shall not exceed an amount~~  
7 ~~that results in capitation payments that are certified by the state's~~  
8 ~~actuary as meeting federal requirements, taking into account the~~  
9 ~~requirement that all of the increased capitation payments under~~  
10 ~~this section shall be paid by the Medi-Cal managed health care~~  
11 ~~plans to hospitals for hospital services to Medi-Cal enrollees of~~  
12 ~~the plan.~~

13 (f) ~~(1) The increased capitation payments to managed health~~  
14 ~~care plans under this section shall be made to support the~~  
15 ~~availability of hospital services and ensure access to hospital~~  
16 ~~services for Medi-Cal beneficiaries. The increased capitation~~  
17 ~~payments to managed health care plans shall commence within 90~~  
18 ~~days of the date on which all necessary federal approvals have~~  
19 ~~been received, and shall include, but not be limited to, the sum of~~  
20 ~~the increased payments for all prior months for which payments~~  
21 ~~are due.~~

22 ~~(2) To secure the necessary funding for the payment or payments~~  
23 ~~made pursuant to paragraph (1), the department may accumulate~~  
24 ~~funds in the Hospital Quality Assurance Revenue Fund, established~~  
25 ~~pursuant to Section 14167.35, for the purpose of funding managed~~  
26 ~~health care capitation payments under this article regardless of the~~  
27 ~~date on which capitation payments are scheduled to be paid in~~  
28 ~~order to secure the necessary total funding for managed health care~~  
29 ~~payments by December 31, 2015.~~

30 (g) ~~Payments to managed health care plans that would be paid~~  
31 ~~consistent with actuarial certification and enrollment in the absence~~  
32 ~~of the payments made pursuant to this section, including, but not~~  
33 ~~limited to, payments described in Section 14182.15, shall not be~~  
34 ~~reduced as a consequence of payments under this section.~~

35 (h) ~~(1) Each managed health care plan shall expend 100 percent~~  
36 ~~of any increased capitation payments it receives under this section~~  
37 ~~on hospital services.~~

38 (2) ~~The department may issue change orders to amend contracts~~  
39 ~~with managed health care plans as needed to adjust monthly~~  
40 ~~capitation payments in order to implement this section.~~

~~(3) For entities contracting with the department pursuant to Article 2.91 (commencing with Section 14089), any incremental increase in capitation rates pursuant to this section shall not be subject to negotiation and approval by the department.~~

~~(i) (1) If federal financial participation is not available for all of the increased capitation payments determined for a month pursuant to this section for any reason, the increased capitation payments mandated by this section for that month shall be reduced proportionately to the amount for which federal financial participation is available.~~

~~(2) The determination under this subdivision for any subject month shall be made after accounting for all federal financial participation necessary for full implementation of Section 14182.15 for that month.~~

~~14169.55. (a) Each managed health care plan receiving increased capitation payments under Section 14169.54 shall expend the capitation rate increases in a manner consistent with actuarial certification, enrollment, and utilization on hospital services. Each managed health care plan shall expend increased capitation payments on hospital services within 30 days of receiving the increased capitation payments to the extent they are made for a subject month that is prior to the date on which the payments are received by the managed health care plan.~~

~~(b) The sum of all expenditures made by a managed health care plan for hospital services pursuant to this section shall equal, or approximately equal, all increased capitation payments received by the managed health care plan, consistent with actuarial certification, enrollment, and utilization, from the department pursuant to Section 14169.54.~~

~~(c) Any delegation or attempted delegation by a managed health care plan of its obligation to expend the capitation rate increases under this section shall not relieve the plan from its obligation to expend those capitation rate increases. Managed health care plans shall submit the documentation that the department may require to demonstrate compliance with this subdivision. The documentation shall demonstrate actual expenditure of the capitation rate increases for hospital services, and not assignment to subcontractors of the managed health care plan's obligation of the duty to expend the capitation rate increases.~~



1 ~~(d) The supplemental hospital payments made by managed~~  
2 ~~health care plans pursuant to this section shall reflect the overall~~  
3 ~~purpose of this article and Article 5.231 (commencing with Section~~  
4 ~~14169.71).~~

5 ~~(e) This article is not intended to create a private right of action~~  
6 ~~by a hospital against a managed care plan provided that the~~  
7 ~~managed health care plan expends all increased capitation payments~~  
8 ~~for hospital services.~~

9 ~~14169.56. (a) Designated public hospitals shall be paid direct~~  
10 ~~grants in support of health care expenditures, which shall not~~  
11 ~~constitute Medi-Cal payments, and which shall be funded by the~~  
12 ~~quality assurance fee set forth in Article 5.231 (commencing with~~  
13 ~~Section 14169.71).~~

14 ~~(1) The aggregate amount of the grants to designated public~~  
15 ~~hospitals shall be forty-five million dollars (\$45,000,000) in the~~  
16 ~~aggregate for the subject fiscal quarters in subject fiscal year~~  
17 ~~2013-14, ninety-three million dollars (\$93,000,000) for subject~~  
18 ~~fiscal year 2014-15, and forty-eight million dollars (\$48,000,000)~~  
19 ~~in the aggregate for the subject fiscal quarters in the subject fiscal~~  
20 ~~year 2015-16. For each subject fiscal year, the director shall~~  
21 ~~allocate the aggregate grant amounts in accordance with paragraph~~  
22 ~~(2).~~

23 ~~(2) (A) Of the direct grant amounts set forth in paragraph (1),~~  
24 ~~the director shall allocate twenty-four million five hundred~~  
25 ~~thousand dollars (\$24,500,000) in the aggregate for the subject~~  
26 ~~fiscal quarters in subject fiscal year 2013-14, fifty million five~~  
27 ~~hundred thousand dollars (\$50,500,000) for subject fiscal year~~  
28 ~~2014-15, and twenty-six million dollars (\$26,000,000) in the~~  
29 ~~aggregate for the subject fiscal quarters in subject fiscal year~~  
30 ~~2015-16, among the designated public hospitals pursuant to a~~  
31 ~~methodology developed in consultation with the designated public~~  
32 ~~hospitals.~~

33 ~~(i) Of the direct grant amounts set forth in this subparagraph,~~  
34 ~~the director shall distribute six million one hundred twenty-five~~  
35 ~~thousand dollars (\$6,125,000) for each subject fiscal quarter in~~  
36 ~~subject fiscal year 2013-14, six million three hundred twelve~~  
37 ~~thousand five hundred dollars (\$6,312,500) for each subject fiscal~~  
38 ~~quarter in subject fiscal year 2014-15, and six million five hundred~~  
39 ~~thousand dollars (\$6,500,000) for each subject fiscal quarter in~~

1 subject fiscal year 2015–16 in accordance with the timeframes  
2 specified in subdivision (a) of Section 14169.59.

3 (ii) ~~Of the direct grant amounts set forth in this subparagraph,~~  
4 ~~the director shall distribute six million one hundred twenty-five~~  
5 ~~thousand dollars (\$6,125,000) for each subject fiscal quarter in~~  
6 ~~subject fiscal year 2013–14, six million three hundred twelve~~  
7 ~~thousand five hundred dollars (\$6,312,500) for each subject fiscal~~  
8 ~~quarter in subject fiscal year 2014–15, and six million five hundred~~  
9 ~~thousand dollars (\$6,500,000) for each subject fiscal quarter in~~  
10 ~~subject fiscal year 2015–16 only upon 100 percent of the rate range~~  
11 ~~increases under subparagraph (B) being distributed to managed~~  
12 ~~health care plans pursuant to subparagraph (B) for the respective~~  
13 ~~subject fiscal quarter. If the rate range increases under subparagraph~~  
14 ~~(B) are distributed to managed health care plans, the direct grant~~  
15 ~~amounts described in this clause shall be distributed to designated~~  
16 ~~public hospitals no later than 30 days after the rate range increases~~  
17 ~~have been distributed to managed health care plans pursuant to~~  
18 ~~subparagraph (B).~~

19 (B) ~~Of the direct grant amounts set forth in paragraph (1), twenty~~  
20 ~~million five hundred thousand dollars (\$20,500,000) in the~~  
21 ~~aggregate for the subject fiscal quarters in subject fiscal year~~  
22 ~~2013–14, forty-two million five hundred thousand dollars~~  
23 ~~(\$42,500,000) for subject fiscal year 2014–15, and twenty-two~~  
24 ~~million dollars (\$22,000,000) in the aggregate for the subject fiscal~~  
25 ~~quarters in subject fiscal year 2015–16 shall be withheld from~~  
26 ~~payment to the designated public hospitals by the director, and~~  
27 ~~shall be used as the nonfederal share for rate range increases, as~~  
28 ~~defined in paragraph (4) of subdivision (b) of Section 14301.4, to~~  
29 ~~risk-based payments to managed care health plans that contract~~  
30 ~~with the department to serve counties where a designated public~~  
31 ~~hospital is located. The rate range increases shall apply to managed~~  
32 ~~care rates for beneficiaries other than newly eligible beneficiaries;~~  
33 ~~as defined in subdivision (s) of Section 17612.2, and shall enable~~  
34 ~~plans to compensate hospitals for Medi-Cal health services and to~~  
35 ~~support the Medi-Cal program. Each managed health care plan~~  
36 ~~shall expend 100 percent of the rate range increases on hospital~~  
37 ~~services within 30 days of receiving the increased payments. Rate~~  
38 ~~range increases funded under this subparagraph shall be allocated~~  
39 ~~among plans pursuant to a methodology developed in consultation~~  
40 ~~with the hospital community.~~

1     ~~(3) Notwithstanding any other law, any amounts withheld from~~  
2     ~~payment to the designated public hospitals by the director as the~~  
3     ~~nonfederal share for rate range increases, including those described~~  
4     ~~in subparagraph (B) of paragraph (2), shall not be considered~~  
5     ~~hospital fee direct grants as defined under subdivision (k) of~~  
6     ~~Section 17612.2 and shall not be included in the determination~~  
7     ~~under paragraph (1) of subdivision (a) of Section 17612.3.~~

8     ~~(b) Nondesignated public hospitals shall be paid direct grants~~  
9     ~~in support of health care expenditures, which shall not constitute~~  
10    ~~Medi-Cal payments, and which shall be funded by the quality~~  
11    ~~assurance fee set forth in Article 5.231 (commencing with Section~~  
12    ~~14169.71).~~

13    ~~(1) The aggregate amount of the grants to nondesignated public~~  
14    ~~hospitals shall be twelve million five hundred thousand dollars~~  
15    ~~(\$12,500,000) in the aggregate for the subject fiscal quarters in~~  
16    ~~subject fiscal year 2013–14, twenty-five million dollars~~  
17    ~~(\$25,000,000) for subject fiscal year 2014–15, and twelve million~~  
18    ~~five hundred thousand dollars (\$12,500,000) in the aggregate for~~  
19    ~~the subject fiscal quarters in subject fiscal year 2015–16. For each~~  
20    ~~subject fiscal year, the director shall allocate the aggregate grant~~  
21    ~~amounts in accordance with paragraph (2).~~

22    ~~(2) (A) Of the direct grant amounts set forth in paragraph (1),~~  
23    ~~the director shall allocate two million five hundred thousand dollars~~  
24    ~~(\$2,500,000) in the aggregate for the subject fiscal quarters in~~  
25    ~~subject fiscal year 2013–14, five million dollars (\$5,000,000) for~~  
26    ~~subject fiscal year 2014–15, and two million five hundred thousand~~  
27    ~~dollars (\$2,500,000) in the aggregate for the subject fiscal quarters~~  
28    ~~in subject fiscal year 2015–16 among the nondesignated public~~  
29    ~~hospitals pursuant to a methodology developed in consultation~~  
30    ~~with the nondesignated public hospitals.~~

31    ~~(B) Of the direct grant amounts set forth in paragraph (1), ten~~  
32    ~~million dollars (\$10,000,000) in the aggregate for the subject fiscal~~  
33    ~~quarters in subject fiscal year 2013–14, twenty million dollars~~  
34    ~~(\$20,000,000) for subject fiscal year 2014–15, and ten million~~  
35    ~~dollars (\$10,000,000) in the aggregate for the subject fiscal quarters~~  
36    ~~in subject fiscal year 2015–16 shall be withheld from payment to~~  
37    ~~the nondesignated public hospitals by the director, and shall be~~  
38    ~~used as the nonfederal share for rate range increases, as defined~~  
39    ~~in paragraph (4) of subdivision (b) of Section 14301.4, to risk-based~~  
40    ~~payments to managed care health plans that contract with the~~

1 department. The rate range increases shall enable plans to  
2 compensate hospitals for Medi-Cal health services and to support  
3 the Medi-Cal program. Each managed health care plan shall expend  
4 100 percent of the rate range increases on hospital services within  
5 30 days of receiving the increased payments. Rate range increases  
6 funded under this subparagraph shall be allocated among plans  
7 pursuant to a methodology developed in consultation with the  
8 hospital community.

9 (e) If the amounts set forth in this section for rate range increases  
10 are not actually used for rate range increases as described in this  
11 section, the direct grant amounts set forth in this section that are  
12 withheld pursuant to clause (ii) of subparagraph (A) of paragraph  
13 (1) of subdivision (a) or as the nonfederal share for rate range  
14 increases for rate range increases pursuant to subparagraph (B) of  
15 paragraph (2) of subdivision (a) or subparagraph (B) of paragraph  
16 (2) of subdivision (b) shall be returned to the Hospital Quality  
17 Assurance Revenue Fund subject to subdivision (c) of Section  
18 14169.73.

19 14169.57. (a) The amount of any payments made under this  
20 article to private hospitals, including the amount of payments made  
21 under Sections 14169.52 and 14169.53 and additional payments  
22 to private hospitals by managed health care plans pursuant to  
23 Section 14169.54, shall not be included in the calculation of the  
24 low-income percent or the OBRA 1993 payment limitation, as  
25 defined in paragraph (24) of subdivision (a) of Section 14105.98,  
26 for purposes of determining payments to private hospitals.

27 (b) The amount of any payments made to a hospital under this  
28 article shall not be included in the calculation of stabilization  
29 funding under Article 5.2 (commencing with Section 14166) or  
30 any successor legislation, including legislation implementing  
31 California's Bridge to Reform Section 1115(a) Medicaid  
32 Demonstration (11-W-00193/9).

33 14169.58. (a) (1) Except as provided in this section, all data  
34 and other information relating to a hospital that are used for the  
35 purposes of this article, including, without limitation, the days data  
36 source, shall continue to be used to determine the payments to that  
37 hospital pursuant to this article, regardless of whether the hospital  
38 has undergone one or more changes of ownership.

1     ~~(2) All supplemental payments to a hospital under this article~~  
2     ~~shall be made to the licensee of a hospital on the date the~~  
3     ~~supplemental payment is made.~~

4     ~~(b) The data of separate facilities prior to a consolidation shall~~  
5     ~~be aggregated for the purposes of this article if: (1) a private~~  
6     ~~hospital consolidates with another private hospital, (2) the facilities~~  
7     ~~operate under a consolidated hospital license, (3) data for a period~~  
8     ~~prior to the consolidation is used for purposes of this article, and~~  
9     ~~(4) neither hospital has had a change of ownership on or after the~~  
10    ~~effective date of this article unless paragraph (2) of subdivision~~  
11    ~~(d) has been satisfied by the new owner. Data of a facility that was~~  
12    ~~a separately licensed hospital prior to the consolidation shall not~~  
13    ~~be included in the data, including the days data source, for the~~  
14    ~~purpose of determining payments to the facility under this article~~  
15    ~~for any time period during which the facility is closed. A facility~~  
16    ~~shall be deemed to be closed for purposes of this subdivision on~~  
17    ~~the first day of any period during which the facility has no general~~  
18    ~~acute, psychiatric, or rehabilitation inpatients for at least 30~~  
19    ~~consecutive days. A facility that has been deemed to be closed~~  
20    ~~under this subdivision shall no longer be deemed to be closed on~~  
21    ~~the first subsequent day on which it has general acute, psychiatric,~~  
22    ~~or rehabilitation inpatients.~~

23    ~~(c) The payments to a hospital under this article shall not be~~  
24    ~~made for any period during which the hospital is closed. A hospital~~  
25    ~~shall be deemed to be closed on the first day of any period during~~  
26    ~~which the hospital has no general acute, psychiatric, or~~  
27    ~~rehabilitation inpatients for at least 30 consecutive days. A hospital~~  
28    ~~that has been deemed to be closed under this subdivision shall no~~  
29    ~~longer be deemed to be closed on the first subsequent day on which~~  
30    ~~it has general acute, psychiatric, or rehabilitation inpatients.~~  
31    ~~Payments under this article to a hospital that is closed during any~~  
32    ~~portion of a subject fiscal quarter shall be reduced by applying a~~  
33    ~~fraction, expressed as a percentage, the numerator of which shall~~  
34    ~~be the number of days during the applicable subject fiscal quarter~~  
35    ~~that the hospital is closed during the subject fiscal year and the~~  
36    ~~denominator of which shall be the number of days in the subject~~  
37    ~~fiscal quarter.~~

38    ~~(d) The following provisions shall apply only for purposes of~~  
39    ~~this article and Article 5.231 (commencing with Section 14169.71);~~  
40    ~~and shall have no application outside of this article and Article~~

1 ~~5.231 (commencing with Section 14169.71) nor shall they affect~~  
2 ~~the assumption of any outstanding monetary obligation to the~~  
3 ~~Medi-Cal program:~~

4 ~~(1) The director shall develop and describe in provider bulletins~~  
5 ~~and on the department's Internet Web site a process by which the~~  
6 ~~new operator of a hospital that has a days data source in whole or~~  
7 ~~in part from a previous operator may enter into an agreement with~~  
8 ~~the department to confirm that it is financially responsible or to~~  
9 ~~become financially responsible to the department for the~~  
10 ~~outstanding monetary obligation to the Medi-Cal program of the~~  
11 ~~previous operator in order to avoid being classified as a new~~  
12 ~~hospital for purposes of this article. This process shall be available~~  
13 ~~for changes of ownership that occur before, on, or after January~~  
14 ~~1, 2014.~~

15 ~~(2) The outstanding monetary obligation referred to in~~  
16 ~~subdivision (o) of Section 14169.51 and subdivision (u) of Section~~  
17 ~~14169.71 shall include liabilities for all of the following:~~

18 ~~(A) Payment of the quality assurance fee established pursuant~~  
19 ~~to Article 5.231 (commencing with Section 14169.71).~~

20 ~~(B) Known overpayments that have been asserted by the~~  
21 ~~department or its fiscal intermediary by sending a written~~  
22 ~~communication that is received by the hospital prior to the date~~  
23 ~~that the new operator becomes the licensee of the hospital.~~

24 ~~(C) Overpayments that are asserted after that date and arise from~~  
25 ~~customary reconciliations of payments, such as cost report~~  
26 ~~settlements, and, with the exception of overpayments described in~~  
27 ~~subparagraph (B), shall exclude liabilities arising from the~~  
28 ~~fraudulent or intentionally criminal act of a prior operator if the~~  
29 ~~new operator did not knowingly participate in or continue that~~  
30 ~~fraudulent or criminal act after becoming the licensee.~~

31 ~~(3) The department shall have the discretion to determine~~  
32 ~~whether the new owner properly and fully agreed to be financially~~  
33 ~~responsible for the outstanding monetary obligation in connection~~  
34 ~~with the Medi-Cal program and seek additional assurances as the~~  
35 ~~department deems necessary. However, a new owner that executes~~  
36 ~~an agreement with the department as described in paragraph (1)~~  
37 ~~shall be conclusively deemed to have agreed to be financially~~  
38 ~~responsible for the outstanding monetary obligation in connection~~  
39 ~~with the Medi-Cal program. The department may establish the~~  
40 ~~terms for satisfying the outstanding monetary obligation in~~

1 connection with the Medi-Cal program, including, but not limited  
2 to, recoupment from amounts payable to the hospital under this  
3 section.

4 14169.59. The department shall make disbursements from the  
5 Hospital Quality Assurance Revenue Fund consistent with all of  
6 the following:

7 (a) Fund disbursements shall be made periodically within 15  
8 days of each date on which quality assurance fees are due from  
9 hospitals.

10 (b) The funds shall be disbursed in accordance with the order  
11 of priority set forth in subdivision (b) of Section 14169.73, except  
12 that funds may be set aside for increased capitation payments to  
13 managed care health plans pursuant to subdivision (f) of Section  
14 14169.54.

15 (c) The funds shall be disbursed in each payment cycle in  
16 accordance with the order of priority set forth in subdivision (b)  
17 of Section 14169.73 as modified by subdivision (b) so that the  
18 supplemental payments, direct grants to hospitals, and increased  
19 capitation payments to managed health care plans are made to the  
20 maximum extent for which funds are available.

21 (d) To the maximum extent possible, consistent with the  
22 availability of funds in the Hospital Quality Assurance Revenue  
23 Fund and the timing of federal approvals, the supplemental  
24 payments, direct grants to hospitals, and increased capitation  
25 payments to managed health care plans under this article shall be  
26 made before December 31, 2015.

27 (e) The aggregate amount of funds to be disbursed to private  
28 hospitals shall be determined under Sections 14169.52 and  
29 14169.53. The aggregate amount of funds to be disbursed to  
30 managed health care plans shall be determined under Section  
31 14169.54. The aggregate amount of direct grants to designated  
32 and nondesignated public hospitals shall be determined under  
33 Section 14169.56.

34 14169.60. (a) Exclusive of payments made under former  
35 Article 5.21 (commencing with Section 14167.1), former Article  
36 5.226 (commencing with Section 14168.1), and Article 5.228  
37 (commencing with Section 14169.1), payment rates for hospital  
38 outpatient services, furnished by private hospitals, nondesignated  
39 public hospitals, and designated public hospitals before December

1 31, 2015, exclusive of amounts payable under this article, shall  
2 not be reduced below the rates in effect on January 1, 2014.

3 (b) Rates payable to hospitals for hospital inpatient services  
4 furnished before December 31, 2015, under contracts negotiated  
5 pursuant to the selective provider contracting program under Article  
6 2.6 (commencing with Section 14081), shall not be reduced below  
7 the contract rates in effect on January 1, 2014. This subdivision  
8 shall not prohibit changes to the supplemental payments paid to  
9 individual hospitals under Sections 14166.12, 14166.17, and  
10 14166.23, provided that the aggregate amount of the payments for  
11 each subject fiscal year is not less than the minimum amount  
12 permitted under former Section 14167.13.

13 (c) Notwithstanding Section 14105.281, exclusive of payments  
14 made under former Article 5.21 (commencing with Section  
15 14167.1), former Article 5.226 (commencing with Section  
16 14168.1), and Article 5.228 (commencing with Section 14169.1),  
17 payments to private hospitals for hospital inpatient services  
18 furnished before January 1, 2014, that are not reimbursed under a  
19 contract negotiated pursuant to the selective provider contracting  
20 program under Article 2.6 (commencing with Section 14081),  
21 exclusive of amounts payable under this article, shall not be less  
22 than the amount of payments that would have been made under  
23 the payment methodology in effect on the effective date of this  
24 article.

25 (d) The requirements in subdivisions (b) and (c) shall be met  
26 with respect to the inpatient hospital reimbursement methodology  
27 based on diagnosis-related groups pursuant to Section 14105.28  
28 if the rates paid under the Medi-Cal inpatient hospital  
29 reimbursement methodology based on diagnosis-related groups  
30 result in an average payment per discharge to all hospitals subject  
31 to the new reimbursement methodology, calculated on an aggregate  
32 basis per subject fiscal year, exclusive of amounts payable under  
33 this article, amounts payable under Sections 14166.11 and  
34 14166.23, and if amounts payable under Sections 14166.12 and  
35 14166.17 are not included in the payments under the  
36 diagnosis-related group methodology and continue to be paid  
37 separately to hospitals, exclusive of those amounts, that is not less  
38 than the average payment per discharge to the hospitals, exclusive  
39 of amounts payable under this article, amounts payable under  
40 Sections 14166.11 and 14166.23, and if amounts payable under



1 Sections 14166.12 and 14166.17 are not included in the payments  
2 under the diagnosis-related group methodology and continue to  
3 be paid separately to hospitals, exclusive of those amounts,  
4 calculated on an aggregate basis for the six months ending  
5 December 31, 2013, adjusted, in consultation with the hospital  
6 community, to reflect the movement of populations into managed  
7 care under Article 5.4 (commencing with Section 14180).

8 (e) ~~Solely for purposes of this article, a rate reduction or a~~  
9 ~~change in a rate methodology that is enjoined by a court shall be~~  
10 ~~included in the determination of a rate or a rate methodology until~~  
11 ~~all appeals or judicial reviews have been exhausted and the rate~~  
12 ~~reduction or change in rate methodology has been permanently~~  
13 ~~enjoined, denied by the federal government, or otherwise~~  
14 ~~permanently prevented from being implemented.~~

15 (f) ~~Disproportionate share replacement payments to private~~  
16 ~~hospitals shall be not less than the amount determined pursuant to~~  
17 ~~Section 14166.11. For purposes of this subdivision, references to~~  
18 ~~Section 14166.11 are to the version of Section 14166.11 in effect~~  
19 ~~on the effective date of the act that added this subdivision.~~

20 14169.61. (a) The director shall do all of the following:

21 (1) ~~Promptly submit any state plan amendment or waiver request~~  
22 ~~that may be necessary to implement this article.~~

23 (2) ~~Promptly seek federal approvals or waivers as may be~~  
24 ~~necessary to implement this article and to obtain federal financial~~  
25 ~~participation to the maximum extent possible for the payments~~  
26 ~~under this article.~~

27 (3) ~~Amend the contracts between the managed health care plans~~  
28 ~~and the department as necessary to incorporate the provisions of~~  
29 ~~Sections 14169.54 and 14169.55 and promptly seek all necessary~~  
30 ~~federal approvals of those amendments. The department shall~~  
31 ~~pursue amendments to the contracts as soon as possible after the~~  
32 ~~effective date of this article and Article 5.231 (commencing with~~  
33 ~~Section 14169.71), and shall not wait for federal approval of this~~  
34 ~~article or Article 5.231 (commencing with Section 14169.71) prior~~  
35 ~~to pursuing amendments to the contracts. The amendments to the~~  
36 ~~contracts shall, among other provisions, set forth an agreement to~~  
37 ~~increase capitation payments to managed health care plans under~~  
38 ~~Section 14169.54 and increase payments to hospitals under Section~~  
39 ~~14169.55 in a manner that relates back to January 1, 2014, or as~~  
40 ~~soon thereafter as possible, conditioned on obtaining all federal~~

1 ~~approvals necessary for federal financial participation for the~~  
2 ~~increased capitation payments to the managed health care plans.~~

3 ~~(b) In implementing this article, the department may utilize the~~  
4 ~~services of the Medi-Cal fiscal intermediary through a change~~  
5 ~~order to the fiscal intermediary contract to administer this program,~~  
6 ~~consistent with the requirements of Sections 14104.6, 14104.7,~~  
7 ~~14104.8, and 14104.9. Contracts entered into for purposes of~~  
8 ~~implementing this article or Article 5.231 (commencing with~~  
9 ~~Section 14169.71) shall not be subject to Part 2 (commencing with~~  
10 ~~Section 10100) of Division 2 of the Public Contract Code.~~

11 ~~(c) This article shall become inoperative if either of the~~  
12 ~~following occurs:~~

13 ~~(1) In the event, and on the effective date, of a final judicial~~  
14 ~~determination made by any court of appellate jurisdiction or a final~~  
15 ~~determination by the federal Department of Health and Human~~  
16 ~~Services or the federal Centers for Medicare and Medicaid Services~~  
17 ~~that Section 14169.52 or 14169.53 cannot be implemented. This~~  
18 ~~paragraph shall not apply to a final judicial determination made~~  
19 ~~by any court of appellate jurisdiction in a case brought by hospitals~~  
20 ~~located outside the State of California.~~

21 ~~(2) In the event both of the following conditions exist:~~

22 ~~(A) The federal Centers for Medicare and Medicaid Services~~  
23 ~~denies approval for, or does not approve before January 1, 2016,~~  
24 ~~the implementation of Section 14169.52, Section 14169.53, or the~~  
25 ~~quality assurance fee established pursuant to Article 5.231~~  
26 ~~(commencing with Section 14169.71).~~

27 ~~(B) Section 14169.52, Section 14169.53, or Article 5.231~~  
28 ~~(commencing with Section 14169.71) cannot be modified by the~~  
29 ~~department pursuant to subdivision (c) of Section 14169.73 in~~  
30 ~~order to meet the requirements of federal law or to obtain federal~~  
31 ~~approval.~~

32 ~~(d) If this article becomes inoperative pursuant to paragraph (1)~~  
33 ~~of subdivision (c) and the determination applies to any period or~~  
34 ~~periods of time prior to the effective date of the determination, the~~  
35 ~~department shall have authority to recoup all payments made~~  
36 ~~pursuant to this article during that period or those periods of time.~~

37 ~~(e) In the event any hospital, or any party on behalf of a hospital,~~  
38 ~~initiates a case or proceeding in any state or federal court in which~~  
39 ~~the hospital seeks any relief of any sort whatsoever, including, but~~  
40 ~~not limited to, monetary relief, injunctive relief, declaratory relief,~~

1 or a writ, based in whole or in part on a contention that any or all  
2 of this article or Article 5.231 (commencing with Section 14169.71)  
3 is unlawful and may not be lawfully implemented, both of the  
4 following shall apply:

5 (1) Payments shall not be made to the hospital pursuant to this  
6 article until the case or proceeding is finally resolved, including  
7 the final disposition of all appeals.

8 (2) Any amount computed to be payable to the hospital pursuant  
9 to this article shall be withheld by the department and shall be paid  
10 to the hospital only after the case or proceeding is finally resolved,  
11 including the final disposition of all appeals.

12 (f) Subject to Section 14169.74, no payment shall be made under  
13 this article until all necessary federal approvals for the payment  
14 and for the fee provisions in Article 5.231 (commencing with  
15 Section 14169.71) have been obtained and the fee has been  
16 imposed and collected. Notwithstanding any other law, payments  
17 under this article shall be made only to the extent that the fee  
18 established in Article 5.231 (commencing with Section 14169.71)  
19 is collected and available to cover the nonfederal share of the  
20 payments.

21 (g) A hospital's receipt of payments under this article for  
22 services rendered prior to the effective date of this article is  
23 conditioned on the hospital's continued participation in Medi-Cal  
24 for at least 30 days after the effective date of this article.

25 (h) All payments made by the department to hospitals and  
26 managed health care plans under this article shall be made only  
27 from the following:

28 (1) The quality assurance fee set forth in Article 5.231  
29 (commencing with Section 14169.71) and due and payable on or  
30 before December 31, 2015, along with any interest or other  
31 investment income thereon.

32 (2) Federal reimbursement and any other related federal funds.

33 (i) In order to ensure access to care for hospital services, the  
34 director shall seek federal approval for supplemental payments for  
35 hospital services provided to all Medi-Cal populations, including  
36 the optional and expansion populations.

37 14169.62. Notwithstanding any other provision of this article  
38 or Article 5.231 (commencing with Section 14169.71), the director  
39 may proportionately reduce the amount of any supplemental  
40 payments or increased capitation payments under this article to

1 the extent that the payment would result in the reduction of other  
2 amounts payable to a hospital or managed health care plan due to  
3 the application of federal law.

4 ~~14169.63. The director may, pursuant to Section 14169.80,~~  
5 ~~decide not to implement or to discontinue implementation of this~~  
6 ~~article and Article 5.231 (commencing with Section 14169.71),~~  
7 ~~and to retroactively invalidate the requirements for supplemental~~  
8 ~~payments or other payments under this article.~~

9 ~~14169.64. (a) This article shall remain operative only until the~~  
10 ~~later of the following:~~

11 ~~(1) January 1, 2017.~~

12 ~~(2) The date of the last payment of the quality assurance fee~~  
13 ~~payments pursuant to Article 5.231 (commencing Section~~  
14 ~~14169.71).~~

15 ~~(3) The date of the last payment from the department pursuant~~  
16 ~~to this article.~~

17 ~~(b) If this article becomes inoperative under paragraph (1) of~~  
18 ~~subdivision (a), this article shall be repealed on January 1, 2017,~~  
19 ~~unless a later enacted statute enacted before that date, deletes or~~  
20 ~~extends that date.~~

21 ~~(c) If this article becomes inoperative under paragraph (2) or~~  
22 ~~(3) of subdivision (a), this article shall be repealed on January 1~~  
23 ~~of the year following the date this article becomes inoperative,~~  
24 ~~unless a later enacted statute enacted before that date, deletes or~~  
25 ~~extends that date.~~

26 ~~14169.65. Notwithstanding any other law, if federal approval~~  
27 ~~or a letter that indicates likely federal approval in accordance with~~  
28 ~~Section 14169.74 has not been received on or before December~~  
29 ~~1, 2015, then this article shall become inoperative, and as of~~  
30 ~~December 1, 2015, is repealed, unless a later enacted statute, that~~  
31 ~~is enacted before December 1, 2015, deletes or extends that date.~~

32 ~~14169.66. Notwithstanding Chapter 3.5 (commencing with~~  
33 ~~Section 11340) of Part 1 of Division 3 of Title 2 of the Government~~  
34 ~~Code, the department shall implement this article by means of~~  
35 ~~policy letters or similar instructions, without taking further~~  
36 ~~regulatory action.~~

37 ~~14169.67. If the director determines that this article has become~~  
38 ~~inoperative pursuant to Section 14169.61, 14169.64, 14169.65, or~~  
39 ~~14169.80, the director shall execute a declaration stating that this~~  
40 ~~determination has been made and stating the basis for this~~

1 determination. The director shall retain the declaration and provide  
2 a copy, within five working days of the execution of the  
3 declaration, to the fiscal and appropriate policy committees of the  
4 Legislature. In addition, the director shall post the declaration on  
5 the department's Internet Web site and the director shall send the  
6 declaration to the Secretary of State, the Secretary of the Senate,  
7 the Chief Clerk of the Assembly, and the Legislative Counsel.

8 ~~14169.68. (a) It is the intent of the Legislature to consider~~  
9 ~~legislation requiring the director to seek approval to increase~~  
10 ~~payments to hospitals in accordance with Section 14169.52, Section~~  
11 ~~14169.53, and Section 14169.54, and to adopt a corresponding~~  
12 ~~increase in the fee imposed pursuant to Article 5.231 (commencing~~  
13 ~~with Section 14169.71), consistent with federal law and regulations;~~  
14 ~~if the director determines that the maximum available upper~~  
15 ~~payment limits described in subdivision (a) of Section 14169.52~~  
16 ~~or subdivision (a) of Section 14169.53, or the amount of federal~~  
17 ~~financial participation for increased capitation payments to~~  
18 ~~managed care health plans in subdivision (c) of Section 14169.54,~~  
19 ~~have increased during the program period.~~

20 ~~(b) The legislation described in subdivision (a) shall do both of~~  
21 ~~the following:~~

22 ~~(1) Require the director to work in consultation with the hospital~~  
23 ~~community in seeking any necessary approvals from the federal~~  
24 ~~Centers for Medicare and Medicaid Services to increase payments~~  
25 ~~to hospitals and to impose corresponding fee increases.~~

26 ~~(2) Require that, in the event that the director determines that~~  
27 ~~the maximum available upper payment limits in subdivision (a)~~  
28 ~~of Section 14169.52 or subdivision (a) of Section 14169.53, or the~~  
29 ~~amount of federal financial participation for increased capitation~~  
30 ~~payments to managed care health plans in subdivision (c) of Section~~  
31 ~~14169.54, have increased during the program period, the increases~~  
32 ~~shall first be made available for the purposes of this section prior~~  
33 ~~to being used for other purposes.~~

34 ~~(c) Notwithstanding any other provision of this article or Article~~  
35 ~~5.231 (commencing with Section 14169.71), failure to secure, or~~  
36 ~~denial of, any necessary federal approvals required by the~~  
37 ~~legislation described in subdivision (a) shall not affect~~  
38 ~~implementation of this article or Article 5.231 (commencing with~~  
39 ~~Section 14169.71).~~

1     ~~14169.69.—To the extent permitted by federal law and other~~  
2 ~~federal requirements, the director shall develop and describe in~~  
3 ~~provider bulletins and on the department’s Internet Web site a~~  
4 ~~process by which a private general acute care hospital located~~  
5 ~~outside the state that serves Medi-Cal beneficiaries may opt in to~~  
6 ~~pay the quality assurance fee pursuant to Article 5.231~~  
7 ~~(commencing with Section 14169.71) and receive supplemental~~  
8 ~~payments pursuant to this article, in the same manner that the~~  
9 ~~hospital could participate if it were located in the state.~~  
10 ~~Notwithstanding Section 14169.51 and Section 14169.71, the~~  
11 ~~department shall rely on reliable data to make reasonable estimates~~  
12 ~~or projections made with respect to the hospital as to the data,~~  
13 ~~including, but not limited to, the days data source, used to calculate~~  
14 ~~the fees due under Article 5.231 (commencing with Section~~  
15 ~~14169.71) and the supplemental payments under this article.~~  
16 ~~Hospitals located outside the state that would meet the definition~~  
17 ~~of a small and rural hospital if they were located in the state shall~~  
18 ~~be deemed a small and rural hospital for the purposes of Article~~  
19 ~~5.231 (commencing with Section 14169.71) and this article.~~  
20     ~~14169.70.—(a) Notwithstanding any provision of this article or~~  
21 ~~Article 5.231 (commencing with Section 14169.71), the director~~  
22 ~~may correct any identified material and egregious errors in the~~  
23 ~~data, including, but not limited to, the days data source, used in~~  
24 ~~this article or Article 5.231 (commencing with Section 14169.71).~~  
25 ~~An error is material and egregious if the error is clear to the~~  
26 ~~director, based on information the director finds to be reliable, and~~  
27 ~~results in an increase or decrease to a hospital’s supplemental~~  
28 ~~payment under Sections 14169.52 and 14169.53, or an increase~~  
29 ~~or decrease to a hospital’s quality assurance fee payments under~~  
30 ~~Article 5.231 (commencing with Section 14169.71), of at least one~~  
31 ~~million dollars (\$1,000,000) for any subject fiscal year. The~~  
32 ~~director’s determination whether to exercise his or her discretion~~  
33 ~~under this section and any determination made by the director~~  
34 ~~under this section shall not be subject to judicial review, except~~  
35 ~~that a hospital may bring a writ of mandate under Section 1085 of~~  
36 ~~the Code of Civil Procedure to rectify an abuse of discretion by~~  
37 ~~the department in correcting that hospital’s data when that~~  
38 ~~correction results in lower supplemental payments under Sections~~  
39 ~~14169.52 and 14169.53 in the aggregate or higher quality assurance~~

1 fees for that hospital pursuant to Article 5.231 (commencing with  
2 Section 14169.71).

3 (b) ~~Notwithstanding any other law, with respect to a hospital~~  
4 ~~described in subdivision (f) of Section 14165.50, both of the~~  
5 ~~following shall apply:~~

6 (1) ~~The hospital shall not be considered a new hospital, as~~  
7 ~~defined in subdivision (o) of Section 14169.51 for purposes of this~~  
8 ~~article and subdivision (u) of Section 14169.71 for purposes of~~  
9 ~~Article 5.231 (commencing with Section 14169.71).~~

10 (2) ~~To the extent permitted by federal law and other federal~~  
11 ~~requirements, the department shall use the best available and~~  
12 ~~reasonable estimates or projections made with respect to the~~  
13 ~~hospital for an annual period as the data, including, but not limited~~  
14 ~~to, the days data source, used in this article or Article 5.231~~  
15 ~~(commencing with Section 14169.71).~~

16 SEC. 8. ~~Article 5.231 (commencing with Section 14169.71)~~  
17 ~~is added to Chapter 7 of Part 3 of Division 9 of the Welfare and~~  
18 ~~Institutions Code, to read:~~

19  
20 ~~Article 5.231. Private Hospital Quality Assurance Fee Act of~~  
21 ~~2013~~  
22

23 ~~14169.71. For purposes of this article, the following definitions~~  
24 ~~shall apply:~~

25 (a) ~~“Annual fee-for-service days” means the number of~~  
26 ~~fee-for-service days of each hospital subject to the quality assurance~~  
27 ~~fee, as reported on the days data source.~~

28 (b) ~~“Annual managed care days” means the number of managed~~  
29 ~~care days of each hospital subject to the quality assurance fee, as~~  
30 ~~reported on the days data source.~~

31 (c) ~~“Annual Medi-Cal days” means the number of Medi-Cal~~  
32 ~~days of each hospital subject to the quality assurance fee, as~~  
33 ~~reported on the days data source.~~

34 (d) ~~“Converted hospital” means a hospital described in~~  
35 ~~subdivision (b) of Section 14169.51.~~

36 (e) ~~“Days data source” means the hospital’s Annual Financial~~  
37 ~~Disclosure Report filed with the Office of Statewide Health~~  
38 ~~Planning and Development as of June 6, 2013, for its fiscal year~~  
39 ~~ending during 2010.~~

1 (f) “Department” means the State Department of Health Care  
2 Services.

3 (g) “Designated public hospital” shall have the meaning given  
4 in subdivision (d) of Section 14166.1 as of January 1, 2014.

5 (h) “Director” means the Director of Health Care Services.

6 (i) “Exempt facility” means any of the following:

7 (1) A public hospital, which shall include either of the following:

8 (A) A hospital, as defined in paragraph (25) of subdivision (a)  
9 of Section 14105.98.

10 (B) A tax-exempt nonprofit hospital that is licensed under  
11 subdivision (a) of Section 1250 of the Health and Safety Code and  
12 operating a hospital owned by a local health care district, and is  
13 affiliated with the health care district hospital owner by means of  
14 the district’s status as the nonprofit corporation’s sole corporate  
15 member.

16 (2) With the exception of a hospital that is in the Charitable  
17 Research Hospital peer group, as set forth in the 1991 Hospital  
18 Peer Grouping Report published by the department, a hospital that  
19 is a hospital designated as a specialty hospital in the hospital’s  
20 most recently filed Office of Statewide Health Planning and  
21 Development Hospital Annual Financial Disclosure Report as of  
22 January 1, 2014.

23 (3) A hospital that satisfies the Medicare criteria to be a  
24 long-term care hospital.

25 (4) A small and rural hospital as specified in Section 124840  
26 of the Health and Safety Code designated as that in the hospital’s  
27 most recently filed Office of Statewide Health Planning and  
28 Development Hospital Annual Financial Disclosure Report as of  
29 January 1, 2014.

30 (j) “Federal approval” means the approval by the federal  
31 government of both the quality assurance fee established pursuant  
32 to this article and the payments to private hospitals described in  
33 Article 5.230 (commencing with Section 14169.51).

34 (k) (1) “Fee-for-service per diem quality assurance fee rate”  
35 means a fixed daily fee on fee-for-service days.

36 (2) The fee-for-service per diem quality assurance fee rate shall  
37 be three hundred ninety-nine dollars and thirty-six cents (\$399.36)  
38 per day for the 2014 calendar year and four hundred fifty-four  
39 dollars and seventy-nine cents (\$454.79) per day for the 2015  
40 calendar year.



1 ~~(3) Upon federal approval or conditional federal approval~~  
2 ~~described in Section 14169.74, the director shall determine the~~  
3 ~~fee-for-service per diem quality assurance fee rate based on the~~  
4 ~~funds required to make the payments specified in Article 5.230~~  
5 ~~(commencing with Section 14169.51), in consultation with the~~  
6 ~~hospital community.~~

7 ~~(l) “Fee-for-service days” means inpatient hospital days where~~  
8 ~~the service type is reported as “acute care,” “psychiatric care,” and~~  
9 ~~“rehabilitation care,” and the payer category is reported as~~  
10 ~~“Medicare traditional,” “county indigent programs traditional,”~~  
11 ~~“other third parties traditional,” “other indigent,” and “other~~  
12 ~~payers,” for purposes of the Annual Financial Disclosure Report~~  
13 ~~submitted by hospitals to the Office of Statewide Health Planning~~  
14 ~~and Development.~~

15 ~~(m) “General acute care hospital” means any hospital licensed~~  
16 ~~pursuant to subdivision (a) of Section 1250 of the Health and Safety~~  
17 ~~Code.~~

18 ~~(n) “Hospital community” means any general acute care hospital~~  
19 ~~and any hospital industry organization that represents general acute~~  
20 ~~care hospitals.~~

21 ~~(o) “Managed care days” means inpatient hospital days where~~  
22 ~~the service type is reported as “acute care,” “psychiatric care,” and~~  
23 ~~“rehabilitation care,” and the payer category is reported as~~  
24 ~~“Medicare managed care,” “county indigent programs managed~~  
25 ~~care,” and “other third parties managed care,” for purposes of the~~  
26 ~~Annual Financial Disclosure Report submitted by hospitals to the~~  
27 ~~Office of Statewide Health Planning and Development.~~

28 ~~(p) “Managed care per diem quality assurance fee rate” means~~  
29 ~~a fixed fee on managed care days of one hundred forty-five dollars~~  
30 ~~(\$145) per day for the 2014 calendar year and one hundred seventy~~  
31 ~~dollars (\$170) per day for the 2015 calendar year.~~

32 ~~(q) “Medi-Cal days” means inpatient hospital days where the~~  
33 ~~service type is reported as “acute care,” “psychiatric care,” and~~  
34 ~~“rehabilitation care,” and the payer category is reported as~~  
35 ~~“Medi-Cal traditional” and “Medi-Cal managed care,” for purposes~~  
36 ~~of the Annual Financial Disclosure Report submitted by hospitals~~  
37 ~~to the Office of Statewide Health Planning and Development.~~

38 ~~(r) “Medi-Cal fee-for-service days” means inpatient hospital~~  
39 ~~days where the service type is reported as “acute care,” “psychiatric~~  
40 ~~care,” and “rehabilitation care,” and the payer category is reported~~

1 as “Medi-Cal traditional” for purposes of the Annual Financial  
2 Disclosure Report submitted by hospitals to the Office of Statewide  
3 Health Planning and Development.

4 (s) “Medi-Cal managed care days” means inpatient hospital  
5 days as reported on the days data source when the service type is  
6 reported as “acute care,” “psychiatric care,” and “rehabilitation  
7 care,” and the payer category is reported as “Medi-Cal managed  
8 care” for purposes of the Annual Financial Disclosure Report  
9 submitted by hospitals to the Office of Statewide Health Planning  
10 and Development.

11 (t) “Medi-Cal per diem quality assurance fee rate” means a fixed  
12 fee on Medi-Cal days of four hundred seventy-six dollars and  
13 twenty-three cents (\$476.23) per day for the 2014 calendar year  
14 and five hundred forty-seven dollars and sixty-eight cents (\$547.68)  
15 for the 2015 calendar year.

16 (u) “New hospital” means a hospital operation, business, or  
17 facility functioning under current or prior ownership as a private  
18 hospital that does not have a days data source or a hospital that  
19 has a days data source in whole, or in part, from a previous operator  
20 where there is an outstanding monetary obligation owed to the  
21 state in connection with the Medi-Cal program and the hospital is  
22 not, or does not agree to become, financially responsible to the  
23 department for the outstanding monetary obligation in accordance  
24 with subdivision (d) of Section 14169.58.

25 (v) “Nondesignated public hospital” means either of the  
26 following:

27 (1) A public hospital that is licensed under subdivision (a) of  
28 Section 1250 of the Health and Safety Code, is not designated as  
29 a specialty hospital in the hospital’s most recently filed Annual  
30 Financial Disclosure Report as of January 1, 2014, and satisfies  
31 the definition in paragraph (25) of subdivision (a) of Section  
32 14105.98, excluding designated public hospitals.

33 (2) A tax-exempt nonprofit hospital that is licensed under  
34 subdivision (a) of Section 1250 of the Health and Safety Code, is  
35 not designated as a specialty hospital in the hospital’s most recently  
36 filed Annual Financial Disclosure Report as of January 1, 2014,  
37 is operating a hospital owned by a local health care district, and  
38 is affiliated with the health care district hospital owner by means  
39 of the district’s status as the nonprofit corporation’s sole corporate  
40 member.

1     (w) ~~“Prepaid health plan hospital” means a hospital owned by~~  
2     ~~a nonprofit public benefit corporation that shares a common board~~  
3     ~~of directors with a nonprofit health care service plan, which~~  
4     ~~exclusively contracts with no more than two medical groups in the~~  
5     ~~state to provide or arrange for professional medical services for~~  
6     ~~the enrollees of the plan.~~

7     (x) ~~“Prepaid health plan hospital managed care per diem quality~~  
8     ~~assurance fee rate” means a fixed fee on non-Medi-Cal managed~~  
9     ~~care days for prepaid health plan hospitals of eighty-one dollars~~  
10    ~~and twenty cents (\$81.20) per day for the 2014 calendar year and~~  
11    ~~ninety-five dollars and twenty cents (\$95.20) per day for the 2015~~  
12    ~~calendar year.~~

13    (y) ~~“Prepaid health plan hospital Medi-Cal managed care per~~  
14    ~~diem quality assurance fee rate” means a fixed fee on Medi-Cal~~  
15    ~~managed care days for prepaid health plan hospitals of two hundred~~  
16    ~~sixty-six dollars and sixty-nine cents (\$266.69) per day for the~~  
17    ~~2014 calendar year and three hundred six dollars and seventy cents~~  
18    ~~(\$306.70) per day for the 2015 calendar year.~~

19    (z) ~~“Private hospital” means a hospital that meets all of the~~  
20    ~~following conditions:~~

21    (1) ~~Is licensed pursuant to subdivision (a) of Section 1250 of~~  
22    ~~the Health and Safety Code.~~

23    (2) ~~Is in the Charitable Research Hospital peer group, as set~~  
24    ~~forth in the 1991 Hospital Peer Grouping Report published by the~~  
25    ~~department, or is not designated as a specialty hospital in the~~  
26    ~~hospital’s most recently filed Office of Statewide Health Planning~~  
27    ~~and Development Annual Financial Disclosure Report as of January~~  
28    ~~1, 2014.~~

29    (3) ~~Does not satisfy the Medicare criteria to be classified as a~~  
30    ~~long-term care hospital.~~

31    (4) ~~Is a nonpublic hospital, nonpublic converted hospital, or~~  
32    ~~converted hospital as those terms are defined in paragraphs (26)~~  
33    ~~to (28), inclusive, respectively, of subdivision (a) of Section~~  
34    ~~14105.98.~~

35    (5) ~~Is not a nondesignated public hospital or a designated~~  
36    ~~hospital.~~

37    (aa) ~~“Program period” means the period from January 1, 2014,~~  
38    ~~to December 31, 2015, inclusive.~~

1     ~~(ab) “Quality assurance fee” means the quality assurance fee~~  
2     ~~assessed pursuant to Section 14169.72 and collected on the basis~~  
3     ~~of the quarterly quality assurance fee.~~

4     ~~(ac) (1) “Quarterly quality assurance fee” means, with respect~~  
5     ~~to a hospital that is not a prepaid health plan hospital, the sum of~~  
6     ~~all of the following:~~

7     ~~(A) The annual fee-for-service days for an individual hospital~~  
8     ~~multiplied by the fee-for-service per diem quality assurance fee~~  
9     ~~rate, divided by four.~~

10    ~~(B) The annual managed care days for an individual hospital~~  
11    ~~multiplied by the managed care per diem quality assurance fee~~  
12    ~~rate, divided by four.~~

13    ~~(C) The annual Medi-Cal days for an individual hospital~~  
14    ~~multiplied by the Medi-Cal per diem quality assurance fee rate,~~  
15    ~~divided by four.~~

16    ~~(2) “Quarterly quality assurance fee” means, with respect to a~~  
17    ~~hospital that is a prepaid health plan hospital, the sum of all of the~~  
18    ~~following:~~

19    ~~(A) The annual fee-for-service days for an individual hospital~~  
20    ~~multiplied by the fee-for-service per diem quality assurance fee~~  
21    ~~rate, divided by four.~~

22    ~~(B) The annual managed care days for an individual hospital~~  
23    ~~multiplied by the prepaid health plan hospital managed care per~~  
24    ~~diem quality assurance fee rate, divided by four.~~

25    ~~(C) The annual Medi-Cal managed care days for an individual~~  
26    ~~hospital multiplied by the prepaid health plan hospital Medi-Cal~~  
27    ~~managed care per diem quality assurance fee rate, divided by four.~~

28    ~~(D) The annual Medi-Cal fee-for-service days for an individual~~  
29    ~~hospital multiplied by the Medi-Cal per diem quality assurance~~  
30    ~~fee rate, divided by four.~~

31    ~~(ad) “Subject fiscal quarter” means a state fiscal quarter during~~  
32    ~~the program period.~~

33    ~~(ae) “Subject fiscal year” means a state fiscal year that ends~~  
34    ~~after July 1, 2013, and begins before January 1, 2016.~~

35    ~~(af) “Upper payment limit” means a federal upper payment limit~~  
36    ~~on the amount of the Medicaid payment for which federal financial~~  
37    ~~participation is available for a class of service and a class of health~~  
38    ~~care providers, as specified in Part 447 of Title 42 of the Code of~~  
39    ~~Federal Regulations. The applicable upper payment limit shall be~~  
40    ~~separately calculated for inpatient and outpatient hospital services.~~

1     ~~14169.72.—(a) There shall be imposed on each general acute~~  
2 ~~care hospital that is not an exempt facility a quality assurance fee;~~  
3 ~~provided that a quality assurance fee under this article shall not be~~  
4 ~~imposed on a converted hospital for the periods when the hospital~~  
5 ~~is a public hospital or a new hospital.~~

6     ~~(b) The department shall compute the quarterly quality assurance~~  
7 ~~fee for each subject fiscal quarter starting on January 1, 2014, and~~  
8 ~~through and including December 31, 2015.~~

9     ~~(c) Subject to Section 14169.74, upon receipt of federal~~  
10 ~~approval, the following shall become operative:~~

11     ~~(1) Within 10 business days following receipt of the notice of~~  
12 ~~federal approval from the federal government, the department shall~~  
13 ~~send notice to each hospital subject to the quality assurance fee~~  
14 ~~the following information:~~

15     ~~(A) The date that the state received notice of federal approval.~~

16     ~~(B) The quarterly quality assurance fee for each subject fiscal~~  
17 ~~year.~~

18     ~~(C) The date on which each payment is due.~~

19     ~~(2) The hospitals shall pay the quarterly quality assurance fees,~~  
20 ~~based on a schedule developed by the department. The department~~  
21 ~~shall establish the date that each payment is due, provided that the~~  
22 ~~first payment shall be due no earlier than 20 days following the~~  
23 ~~date the department sends the notice pursuant to paragraph (1),~~  
24 ~~and the payments shall be paid at least one month apart, but if~~  
25 ~~possible, the payments shall be paid on a quarterly basis.~~

26     ~~(3) Notwithstanding any other provision of this section, the~~  
27 ~~amount of each hospital's quarterly quality assurance fees for the~~  
28 ~~program period that have not been paid by the hospital before~~  
29 ~~December 15, 2015, shall be paid by the hospital no later than~~  
30 ~~December 15, 2015.~~

31     ~~(4) Each hospital described in subdivision (a) shall pay the~~  
32 ~~quarterly quality assurance fees that are due, if any, in the amounts~~  
33 ~~and at the times set forth in the notice unless superseded by a~~  
34 ~~subsequent notice from the department.~~

35     ~~(d) The quality assurance fee, as paid pursuant to this section,~~  
36 ~~shall be paid by each hospital subject to the fee to the department~~  
37 ~~for deposit in the Hospital Quality Assurance Revenue Fund~~  
38 ~~established pursuant to Section 14167.35. Deposits may be~~  
39 ~~accepted at any time and will be credited toward the program~~  
40 ~~period.~~

~~(e) This section shall become inoperative if the federal Centers for Medicare and Medicaid Services denies approval for, or does not approve before July 1, 2016, the implementation of the quality assurance fee pursuant to this article or the supplemental payments to private hospitals described in Sections 14169.52 and 14169.53.~~

~~(f) In no case shall the aggregate fees collected in a federal fiscal year pursuant to this section, former Section 14167.32, and Sections 14168.32 and 14169.32 exceed the maximum percentage of the annual aggregate net patient revenue for hospitals subject to the fee that is prescribed pursuant to federal law and regulations as necessary to preclude a finding that an indirect guarantee has been created.~~

~~(g) (1) Interest shall be assessed on quality assurance fees not paid on the date due at the greater of 10 percent per annum or the rate at which the department assesses interest on Medi-Cal program overpayments to hospitals that are not repaid when due. Interest shall begin to accrue the day after the date the payment was due and shall be deposited in the Hospital Quality Assurance Revenue Fund.~~

~~(2) If any fee payment is more than 60 days overdue, a penalty equal to the interest charge described in paragraph (1) shall be assessed and due for each month for which the payment is not received after 60 days.~~

~~(h) When a hospital fails to pay all or part of the quality assurance fee on or before the date that payment is due, the department may immediately begin to deduct the unpaid assessment and interest from any Medi-Cal payments owed to the hospital, or, in accordance with Section 12419.5 of the Government Code, from any other state payments owed to the hospital until the full amount is recovered. All amounts, except penalties, deducted by the department under this subdivision shall be deposited in the Hospital Quality Assurance Revenue Fund. The remedy provided to the department by this section is in addition to other remedies available under law.~~

~~(i) The payment of the quality assurance fee shall not be considered as an allowable cost for Medi-Cal cost reporting and reimbursement purposes.~~

~~(j) The department shall work in consultation with the hospital community to implement this article and Article 5.230 (commencing with Section 14169.51).~~

~~(k) This subdivision creates a contractually enforceable promise on behalf of the state to use the proceeds of the quality assurance fee, including any federal matching funds, solely and exclusively for the purposes set forth in this article as they existed on the effective date of this article, to limit the amount of the proceeds of the quality assurance fee to be used to pay for the health care coverage of children to the amounts specified in this article, to limit any payments for the department's costs of administration to the amounts set forth in this article on the effective date of this article, to maintain and continue prior reimbursement levels as set forth in Section 14169.60 on the effective date of that section, and to otherwise comply with all its obligations set forth in Article 5.230 (commencing with Section 14169.51) and this article provided that amendments that arise from, or have as a basis for, a decision, advice, or determination by the federal Centers for Medicare and Medicaid Services relating to federal approval of the quality assurance fee or the payments set forth in this article or Article 5.230 (commencing with Section 14169.51) shall control for the purposes of this subdivision.~~

~~(l) (1) Effective January 1, 2016, the rates payable to hospitals and managed health care plans under Medi-Cal shall be the rates then payable without the supplemental and increased capitation payments set forth in Article 5.230 (commencing with Section 14169.51).~~

~~(2) The supplemental payments and other payments under Article 5.230 (commencing with Section 14169.51) shall be regarded as quality assurance payments, the implementation or suspension of which does not affect a determination of the adequacy of any rates under federal law.~~

~~(m) (1) Subject to paragraph (2), the director may waive any or all interest and penalties assessed under this article in the event that the director determines, in his or her sole discretion, that the hospital has demonstrated that imposition of the full quality assurance fee on the timelines applicable under this article has a high likelihood of creating a financial hardship for the hospital or a significant danger of reducing the provision of needed health care services.~~

~~(2) Waiver of some or all of the interest or penalties under this subdivision shall be conditioned on the hospital's agreement to make fee payments, or to have the payments withheld from~~

1 payments otherwise due from the Medi-Cal program to the hospital;  
2 on a schedule developed by the department that takes into account  
3 the financial situation of the hospital and the potential impact on  
4 services.

5 (3) A decision by the director under this subdivision shall not  
6 be subject to judicial review.

7 (4) If fee payments are remitted to the department after the date  
8 determined by the department to be the final date for calculating  
9 the final supplemental payments under this article and Article  
10 5.230 (commencing with Section 14169.51), the fee payments  
11 shall be retained in the fund for purposes of funding supplemental  
12 payments supported by a hospital quality assurance fee program  
13 implemented under subsequent legislation. However, if  
14 supplemental payments are not implemented under subsequent  
15 legislation, then those fee payments shall be returned to the private  
16 hospitals pro rata based on each hospital's total fee payments under  
17 this article to the extent consistent with federal law.

18 (5) If during the implementation of this article, fee payments  
19 that were due under former Article 5.21 (commencing with Section  
20 14167.1) and former Article 5.22 (commencing with Section  
21 14167.31), or former Article 5.226 (commencing with Section  
22 14168.1) and Article 5.227 (commencing with Section 14168.31),  
23 or Article 5.228 (commencing with Section 14169.1) and Article  
24 5.229 (commencing with Section 14169.31) are remitted to the  
25 department under a payment plan or for any other reason, and the  
26 final date for calculating the final supplemental payments under  
27 those articles has passed, then those fee payments shall be  
28 deposited in the fund to support the uses established by this article.

29 14169.73. (a) (1) All fees required to be paid to the state  
30 pursuant to this article shall be paid in the form of remittances  
31 payable to the department.

32 (2) The department shall directly transmit the fee payments to  
33 the Treasurer to be deposited in the Hospital Quality Assurance  
34 Revenue Fund, created pursuant to Section 14167.35.  
35 Notwithstanding Section 16305.7 of the Government Code, any  
36 interest and dividends earned on deposits in the fund from the  
37 proceeds of the fee assessed pursuant to this article shall be retained  
38 in the fund for purposes specified in subdivision (b).

39 (b) (1) Notwithstanding subdivision (c) of Section 14167.35,  
40 subdivision (b) of Section 14168.33, and subdivision (b) of Section



1 14169.33, all funds from the proceeds of the fee assessed pursuant  
2 to this article in the Hospital Quality Assurance Revenue Fund,  
3 together with any interest and dividends earned on money in the  
4 fund, shall continue to be used exclusively to enhance federal  
5 financial participation for hospital services under the Medi-Cal  
6 program, to provide additional reimbursement to, and to support  
7 quality improvement efforts of, hospitals, and to minimize  
8 uncompensated care provided by hospitals to uninsured patients;  
9 as well as to pay for the state's administrative costs and to provide  
10 funding for children's health coverage, in the following order of  
11 priority:

12 (A) To pay for the department's staffing and administrative  
13 costs directly attributable to implementing Article 5.230  
14 (commencing with Section 14169.51) and this article, not to exceed  
15 three million dollars (\$3,000,000) for the program period.

16 (B) To pay for the health care coverage for children in the  
17 amount of one hundred fifty-five million dollars (\$155,000,000)  
18 for each subject fiscal quarter during the 2014 and 2015 calendar  
19 years.

20 (C) To make increased capitation payments to managed health  
21 care plans pursuant to Article 5.230 (commencing with Section  
22 14169.51).

23 (D) To make increased payments and direct grants to hospitals  
24 pursuant to Article 5.230 (commencing with Section 14169.51).

25 (2) Notwithstanding subdivision (c) of Section 14167.35,  
26 subdivision (b) of Section 14168.33, and subdivision (b) of Section  
27 14169.33, and notwithstanding Section 13340 of the Government  
28 Code, the moneys in the Hospital Quality Assurance Revenue  
29 Fund shall be continuously appropriated without regard to fiscal  
30 year for the purposes of this article, Article 5.230 (commencing  
31 with Section 14169.51), Article 5.229 (commencing with Section  
32 14169.31), Article 5.228 (commencing with Section 14169.1),  
33 Article 5.227 (commencing with Section 14168.31), former Article  
34 5.226 (commencing with Section 14168.1), former Article 5.22  
35 (commencing with Section 14167.31) and former Article 5.21  
36 (commencing with Section 14167.1).

37 (e) Any amounts of the quality assurance fee collected in excess  
38 of the funds required to implement subdivision (b), including any  
39 funds recovered under subdivision (d) of Section 14169.61 or  
40 subdivision (e) of Section 14169.78, shall be refunded to general

1 acute care hospitals, pro rata with the amount of quality assurance  
2 fee paid by the hospital, subject to the limitations of federal law.  
3 If federal rules prohibit the refund described in this subdivision,  
4 the excess funds shall be returned to the private hospitals pro rata  
5 based on each hospital's total fee payments under this article to  
6 the extent consistent with federal law.

7 ~~(d) Any methodology or other provision specified in Article~~  
8 ~~5.230 (commencing with Section 14169.51) or this article may be~~  
9 ~~modified by the department, in consultation with the hospital~~  
10 ~~community, to the extent necessary to meet the requirements of~~  
11 ~~federal law or regulations to obtain federal approval or to enhance~~  
12 ~~the probability that federal approval can be obtained, provided the~~  
13 ~~modifications do not violate the spirit and intent of Article 5.230~~  
14 ~~(commencing with Section 14169.51) or this article and are not~~  
15 ~~inconsistent with the conditions of implementation set forth in~~  
16 ~~Section 14169.80.~~

17 ~~(e) The department, in consultation with the hospital community,~~  
18 ~~shall make adjustments, as necessary, to the amounts calculated~~  
19 ~~pursuant to Section 14169.72 in order to ensure compliance with~~  
20 ~~the federal requirements set forth in Section 433.68 of Title 42 of~~  
21 ~~the Code of Federal Regulations or elsewhere in federal law.~~

22 ~~(f) The department shall request approval from the federal~~  
23 ~~Centers for Medicare and Medicaid Services for the implementation~~  
24 ~~of this article. In making this request, the department shall seek~~  
25 ~~specific approval from the federal Centers for Medicare and~~  
26 ~~Medicaid Services to exempt providers identified in this article as~~  
27 ~~exempt from the fees specified, including the submission, as may~~  
28 ~~be necessary, of a request for waiver of the broad-based~~  
29 ~~requirement, waiver of the uniform fee requirement, or both,~~  
30 ~~pursuant to paragraphs (1) and (2) of subdivision (c) of Section~~  
31 ~~433.68 of Title 42 of the Code of Federal Regulations.~~

32 ~~(g) Notwithstanding Chapter 3.5 (commencing with Section~~  
33 ~~11340) of Part 1 of Division 3 of Title 2 of the Government Code,~~  
34 ~~the department may implement this article or Article 5.230~~  
35 ~~(commencing with Section 14169.51) by means of provider~~  
36 ~~bulletins, all plan letters, or other similar instruction, without taking~~  
37 ~~regulatory action. The department shall also provide notification~~  
38 ~~to the Joint Legislative Budget Committee and to the appropriate~~  
39 ~~policy and fiscal committees of the Legislature within five working~~

1 days when the above-described action is taken in order to inform  
2 the Legislature that the action is being implemented.

3 ~~14169.74. (a) Notwithstanding any other provision of this~~  
4 ~~article or Article 5.230 (commencing with Section 14169.51)~~  
5 ~~requiring federal approvals, the department may impose and collect~~  
6 ~~the quality assurance fee and may make payments under this article~~  
7 ~~and Article 5.230 (commencing with Section 14169.51), including~~  
8 ~~increased capitation payments, based upon receiving a letter from~~  
9 ~~the federal Centers for Medicare and Medicaid Services or the~~  
10 ~~United States Department of Health and Human Services that~~  
11 ~~indicates likely federal approval, but only if and to the extent that~~  
12 ~~the letter is sufficient as set forth in subdivision (b).~~

13 ~~(b) In order for the letter to be sufficient under this section, the~~  
14 ~~director shall find that the letter meets both of the following~~  
15 ~~requirements:~~

16 ~~(1) The letter is in writing and signed by an official of the federal~~  
17 ~~Centers for Medicare and Medicaid Services or an official of the~~  
18 ~~United States Department of Health and Human Services.~~

19 ~~(2) The director, after consultation with the hospital community,~~  
20 ~~has determined, in the exercise of his or her sole discretion, that~~  
21 ~~the letter provides a sufficient level of assurance to justify advanced~~  
22 ~~implementation of the fee and payment provisions.~~

23 ~~(c) Nothing in this section shall be construed as modifying the~~  
24 ~~requirement under Section 14169.61 that payments shall be made~~  
25 ~~only to the extent a sufficient amount of funds collected as the~~  
26 ~~quality assurance fee are available to cover the nonfederal share~~  
27 ~~of those payments.~~

28 ~~(d) Upon notice from the federal government that final federal~~  
29 ~~approval for the fee model under this article or for the supplemental~~  
30 ~~payments to private hospitals under Section 14169.52 or 14169.53~~  
31 ~~has been denied, any fees collected pursuant to this section shall~~  
32 ~~be refunded and any payments made pursuant to this article or~~  
33 ~~Article 5.230 (commencing with Section 14169.51) shall be~~  
34 ~~recouped, including, but not limited to, supplemental payments~~  
35 ~~and grants, increased capitation payments, payments to hospitals~~  
36 ~~by health care plans resulting from the increased capitation~~  
37 ~~payments, and payments for the health care coverage of children.~~  
38 ~~To the extent fees were paid by a hospital that also received~~  
39 ~~payments under this section, the payments may first be recouped~~

1 from fees that would otherwise be refunded to the hospital prior  
2 to the use of any other recoupment method allowed under law.

3 (e) Any payment made pursuant to this section shall be a  
4 conditional payment until final federal approval has been received.

5 (f) The director shall have broad authority under this section to  
6 collect the quality assurance fee for an interim period after receipt  
7 of the letter described in subdivision (a) pending receipt of all  
8 necessary federal approvals. This authority shall include discretion  
9 to determine both of the following:

10 (1) Whether the quality assurance fee should be collected on a  
11 full or pro rata basis during the interim period.

12 (2) The dates on which payments of the quality assurance fee  
13 are due.

14 (g) The department may draw against the Hospital Quality  
15 Assurance Revenue Fund for all administrative costs associated  
16 with implementation under this article or Article 5.230  
17 (commencing with Section 14169.51).

18 (h) This section shall be implemented only to the extent federal  
19 financial participation is not jeopardized by implementation prior  
20 to the receipt of all necessary final federal approvals.

21 14169.75. (a) Notwithstanding any other law, the director shall  
22 have discretion to modify any timeline or timelines in this article  
23 or Article 5.230 (commencing with Section 14169.51) if the letter  
24 that indicates likely federal approval, as described in Section  
25 14169.74, is not secured by December 15, 2015, and the director  
26 determines that it is impossible from an operational perspective  
27 to implement a timeline or timelines without the modification.

28 (b) The department shall notify the fiscal and policy committees  
29 of the Legislature prior to implementing a modified timeline or  
30 timelines under subdivision (a).

31 (c) The department shall consult with representatives of the  
32 hospital community in developing a modified timeline or timelines  
33 pursuant to this section.

34 (d) The discretion to modify timelines under this section shall  
35 include, but not be limited to, discretion to accelerate payments to  
36 plans or hospitals.

37 14169.76. (a) Upon receipt of a letter that indicates likely  
38 federal approval that the director determines is sufficient for  
39 implementation under Section 14169.74, or upon the receipt of  
40 federal approval, the following shall occur:

1     ~~(1) To the maximum extent possible, and consistent with the~~  
2     ~~availability of funds in the Hospital Quality Assurance Revenue~~  
3     ~~Fund, the department shall make all of the payments under Sections~~  
4     ~~14169.52, 14169.53, and 14169.54, including, but not limited to,~~  
5     ~~supplemental payments and increased capitation payments, prior~~  
6     ~~to January 1, 2016, except that the increased capitation payments~~  
7     ~~under Section 14169.54 shall not be made until federal approval~~  
8     ~~is obtained for these payments.~~

9     ~~(2) The department shall make supplemental payments to~~  
10    ~~hospitals under Article 5.230 (commencing with Section 14169.51)~~  
11    ~~consistent with the timeframe described in Section 14169.59 or a~~  
12    ~~modified timeline developed pursuant to Section 14169.75.~~

13    ~~(b) Notwithstanding any other provision of this article or Article~~  
14    ~~5.230 (commencing with Section 14169.51), if the director~~  
15    ~~determines, on or after December 15, 2015, that there are~~  
16    ~~insufficient funds available in the Hospital Quality Assurance~~  
17    ~~Revenue Fund to make all scheduled payments under Article 5.230~~  
18    ~~(commencing with Section 14169.51) before January 1, 2016, he~~  
19    ~~or she shall consult with representatives of the hospital community~~  
20    ~~to develop an acceptable plan for making additional payments to~~  
21    ~~hospitals and managed health care plans to maximize the use of~~  
22    ~~delinquent fee payments or other deposits or interest projected to~~  
23    ~~become available in the fund after December 15, 2015, but before~~  
24    ~~June 15, 2016.~~

25    ~~(c) Nothing in this section shall require the department to~~  
26    ~~continue to make payments under Article 5.230 (commencing with~~  
27    ~~Section 14169.51) if, after the consultation required under~~  
28    ~~subdivision (b), the director determines in the exercise of his or~~  
29    ~~her sole discretion that a workable plan for the continued payments~~  
30    ~~cannot be developed.~~

31    ~~(d) Subdivisions (b) and (c) shall be implemented only if and~~  
32    ~~to the extent federal financial participation is available for~~  
33    ~~continued supplemental payments and to providers and continued~~  
34    ~~increased capitation payments to managed health care plans.~~

35    ~~(e) If any payment or payments made pursuant to this section~~  
36    ~~are found to be inconsistent with federal law, the department shall~~  
37    ~~recoup the payments by means of withholding or any other~~  
38    ~~available remedy.~~

39    ~~(f) Nothing in this section shall be read as affecting the~~  
40    ~~department's ongoing authority to continue, after December 31,~~

1 2015, to collect quality assurance fees imposed on or before  
2 December 31, 2015.

3 14169.77. Notwithstanding any other law, if actual federal  
4 approval or a letter that indicates likely federal approval in  
5 accordance with Section 14169.74 has not been received on or  
6 before December 1, 2015, then this article shall become  
7 inoperative, and as of December 1, 2015, is repealed, unless a later  
8 enacted statute, that is enacted before December 1, 2015, deletes  
9 or extends that date.

10 14169.78. (a) This article shall be implemented only as long  
11 as all of the following conditions are met:

12 (1) Subject to Section 14169.73, the quality assurance fee is  
13 established in a manner that is fundamentally consistent with this  
14 article.

15 (2) The quality assurance fee, including any interest on the fee  
16 after collection by the department, is deposited in a segregated  
17 fund apart from the General Fund.

18 (3) The proceeds of the quality assurance fee, including any  
19 interest and related federal reimbursement, may only be used for  
20 the purposes set forth in this article.

21 (b) No hospital shall be required to pay the quality assurance  
22 fee to the department unless and until the state receives and  
23 maintains federal approval.

24 (c) Hospitals shall be required to pay the quality assurance fee  
25 to the department as set forth in this article only as long as all of  
26 the following conditions are met:

27 (1) The federal Centers for Medicare and Medicaid Services  
28 allows the use of the quality assurance fee as set forth in this article  
29 in accordance with federal approval.

30 (2) Article 5.230 (commencing with Section 14169.51) is  
31 enacted and remains in effect and hospitals are reimbursed the  
32 increased rates for services during the program period, as defined  
33 in Section 14169.51.

34 (3) The full amount of the quality assurance fee assessed and  
35 collected pursuant to this article remains available only for the  
36 purposes specified in this article.

37 (d) This article shall become inoperative if either of the  
38 following occurs:

39 (1) In the event, and on the effective date, of a final judicial  
40 determination made by any court of appellate jurisdiction or a final

1 ~~determination by the United States Department of Health and~~  
2 ~~Human Services or the federal Centers for Medicare and Medicaid~~  
3 ~~Services that the quality assurance fee established pursuant to this~~  
4 ~~article cannot be implemented. This paragraph shall not apply to~~  
5 ~~a final judicial determination made by any court of appellate~~  
6 ~~jurisdiction in a case brought by hospitals located outside the state.~~

7 ~~(2) In the event both of the following conditions exist:~~

8 ~~(A) The federal Centers for Medicare and Medicaid Services~~  
9 ~~denies approval for, or does not approve before January 1, 2016,~~  
10 ~~the implementation of Sections 14169.52 and 14169.53 or this~~  
11 ~~article.~~

12 ~~(B) Section 14169.52, Section 14169.53, or this article cannot~~  
13 ~~be modified by the department pursuant to subdivision (d) of~~  
14 ~~Section 14169.73 in order to meet the requirements of federal law~~  
15 ~~or to obtain federal approval.~~

16 ~~(e) If this article becomes inoperative pursuant to paragraph (1)~~  
17 ~~of subdivision (d) and the determination applies to any period or~~  
18 ~~periods of time prior to the effective date of the determination, the~~  
19 ~~department may recoup all payments made pursuant to Article~~  
20 ~~5.230 (commencing with Section 14169.51) during that period or~~  
21 ~~those periods of time.~~

22 ~~(f) (1) If all necessary final federal approvals are not received~~  
23 ~~as described and anticipated under this article or Article 5.230~~  
24 ~~(commencing with Section 14169.51), the director shall have the~~  
25 ~~discretion and authority to develop procedures for recoupment~~  
26 ~~from managed health care plans, and from hospitals under contract~~  
27 ~~with managed health care plans, of any amounts received pursuant~~  
28 ~~to this article or Article 5.230 (commencing with Section~~  
29 ~~14169.51).~~

30 ~~(2) Any procedure instituted pursuant to this subdivision shall~~  
31 ~~be developed in consultation with representatives from managed~~  
32 ~~health care plans and representatives of the hospital community.~~

33 ~~(3) Any procedure instituted pursuant to this subdivision shall~~  
34 ~~be in addition to all other remedies made available under the law,~~  
35 ~~pursuant to contracts between the department and the managed~~  
36 ~~health care plans, or pursuant to contracts between the managed~~  
37 ~~health care plans and the hospitals.~~

38 ~~14169.79. Notwithstanding any other provision of this article~~  
39 ~~or Article 5.230 (commencing with Section 14169.51),~~  
40 ~~supplemental payments or other payments under Article 5.230~~

1 ~~(commencing with Section 14169.51) shall only be required and~~  
2 ~~payable in any quarter for which a fee payment obligation exists.~~

3 ~~14169.80. (a) This article and Article 5.230 (commencing with~~  
4 ~~Section 14169.51) shall become inoperative and the requirements~~  
5 ~~for supplemental payments or other payments under Article 5.230~~  
6 ~~(commencing with Section 14169.51) shall be retroactively~~  
7 ~~invalidated, on the first day of the first month of the calendar~~  
8 ~~quarter following notification to the Joint Legislative Budget~~  
9 ~~Committee by the Department of Finance, that any of the following~~  
10 ~~have occurred:~~

11 ~~(1) A final judicial determination by the California Supreme~~  
12 ~~Court or any California Court of Appeal that the revenues collected~~  
13 ~~pursuant to this article that are deposited in the Hospital Quality~~  
14 ~~Assurance Revenue Fund are either of the following:~~

15 ~~(A) General Fund proceeds of taxes appropriated pursuant to~~  
16 ~~Article XIII B of the California Constitution, as used in subdivision~~  
17 ~~(b) of Section 8 of Article XVI of the California Constitution.~~

18 ~~(B) Allocated local proceeds of taxes, as used in subdivision~~  
19 ~~(b) of Section 8 of Article XVI of the California Constitution.~~

20 ~~(2) The department has sought but has not received federal~~  
21 ~~financial participation for the supplemental payments and other~~  
22 ~~costs required by this article for which federal financial~~  
23 ~~participation has been sought.~~

24 ~~(3) A lawsuit related to this article or Article 5.230 (commencing~~  
25 ~~with Section 14169.51) is filed against the state and a preliminary~~  
26 ~~injunction or other order has been issued that results in a financial~~  
27 ~~disadvantage to the state.~~

28 ~~(4) The director, in consultation with the Department of Finance,~~  
29 ~~determines that the implementation of this article or Article 5.230~~  
30 ~~(commencing with Section 14169.51) has resulted in a financial~~  
31 ~~disadvantage to the state.~~

32 ~~(b) For purposes of this section, “financial disadvantage to the~~  
33 ~~state” means either of the following:~~

34 ~~(1) A loss of federal financial participation.~~

35 ~~(2) A cost to the General Fund, that is equal to or greater than~~  
36 ~~one-quarter of 1 percent of the General Fund expenditures~~  
37 ~~authorized in the most recent annual Budget Act.~~

38 ~~(c) (1) The director shall have the authority to recoup any~~  
39 ~~payments made under Article 5.230 (commencing with Section~~  
40 ~~14169.51) if any of the following apply:~~



1     ~~(A) Recoupment of payments made under Article 5.230~~  
2     ~~(commencing with Section 14169.51) is ordered by a court.~~

3     ~~(B) Federal financial participation is not available for payments~~  
4     ~~made under Article 5.230 (commencing with Section 14169.51)~~  
5     ~~for which federal financial participation has been sought.~~

6     ~~(C) Recoupment of payments made under Article 5.230~~  
7     ~~(commencing with Section 14169.51) is necessary to prevent a~~  
8     ~~General Fund cost that is estimated to be equal to or greater than~~  
9     ~~one-quarter of 1 percent of the General Fund expenditures~~  
10    ~~authorized in the most recent annual Budget Act and that results~~  
11    ~~from implementation of a court order or the unavailability of~~  
12    ~~federal financial participation.~~

13    ~~(2) In the event payments are recouped for a particular quarter,~~  
14    ~~fees paid by a hospital for that quarter pursuant to this article shall~~  
15    ~~be refunded to the extent that the hospital meets both of the~~  
16    ~~following conditions:~~

17    ~~(A) The hospital has actually paid the fee for the subject quarter~~  
18    ~~and for all prior quarters.~~

19    ~~(B) The hospital has returned the payment received pursuant to~~  
20    ~~Article 5.230 (commencing with Section 14169.51) for that quarter,~~  
21    ~~or has had that payment recouped through a withholding of funds~~  
22    ~~owed by Medi-Cal or other state payments, or recouped through~~  
23    ~~other means.~~

24    ~~(d) In the event the department determines that recoupment of~~  
25    ~~supplemental payments is necessary to implement any provision~~  
26    ~~of this section, the department may recoup payments made pursuant~~  
27    ~~to Article 5.230 (commencing with Section 14169.51) from fees~~  
28    ~~paid by the hospital pursuant to this article.~~

29    ~~(e) Concurrent with invoking any provision of this section, the~~  
30    ~~director shall notify the fiscal and appropriate policy committees~~  
31    ~~of the Legislature of the intended action and the specific reason~~  
32    ~~or reasons for the proposed action.~~

33    ~~14169.81. Notwithstanding Chapter 3.5 (commencing with~~  
34    ~~Section 11340) of Part 1 of Division 3 of Title 2 of the Government~~  
35    ~~Code, the department shall implement this article by means of~~  
36    ~~policy letters or similar instructions, without taking further~~  
37    ~~regulatory action.~~

38    ~~14169.82. (a) This article shall remain operative only until the~~  
39    ~~later of the following:~~

40    ~~(1) January 1, 2017.~~

1     ~~(2) The date of the last payment of the quality assurance fee~~  
2     ~~payments pursuant to this article.~~

3     ~~(3) The date of the last payment from the department pursuant~~  
4     ~~to Article 5.230 (commencing with Section 14169.51).~~

5     ~~(b) If this article becomes inoperative under paragraph (1) of~~  
6     ~~subdivision (a), this article shall be repealed on January 1, 2017,~~  
7     ~~unless a later enacted statute enacted before that date, deletes or~~  
8     ~~extends that date.~~

9     ~~(c) If this article becomes inoperative under paragraph (2) or~~  
10    ~~(3) of subdivision (a), this article shall be repealed on January 1~~  
11    ~~of the year following the date this article becomes inoperative,~~  
12    ~~unless a later enacted statute enacted before that date, deletes or~~  
13    ~~extends that date.~~

14    ~~14169.83. If the director determines that this article has become~~  
15    ~~inoperative pursuant to Section 14169.77, 14169.78, 14169.80, or~~  
16    ~~14169.82, or that Section 14169.72 has become inoperative~~  
17    ~~pursuant to subdivision (c) of that section, the director shall execute~~  
18    ~~a declaration stating that this determination has been made and~~  
19    ~~stating the basis for this determination. The director shall retain~~  
20    ~~the declaration and provide a copy, within five working days of~~  
21    ~~the execution of the declaration, to the fiscal and appropriate policy~~  
22    ~~committees of the Legislature. In addition, the director shall post~~  
23    ~~the declaration on the department's Internet Web site and the~~  
24    ~~director shall send the declaration to the Secretary of State, the~~  
25    ~~Secretary of the Senate, the Chief Clerk of the Assembly, and the~~  
26    ~~Legislative Counsel.~~

27    ~~14169.84. (a) (1) Except as provided in this section, all data~~  
28    ~~and other information relating to a hospital that are used for the~~  
29    ~~purposes of this article, including, without limitation, the days data~~  
30    ~~source, shall continue to be used to determine the quality assurance~~  
31    ~~fees due from that hospital pursuant to this article, regardless of~~  
32    ~~whether the hospital has undergone one or more changes of~~  
33    ~~ownership.~~

34    ~~(2) All quality assurance fee payments under this article shall~~  
35    ~~be paid by the licensee of a hospital on the date the quarterly~~  
36    ~~quality assurance fee payment is due.~~

37    ~~(b) The data of separate facilities prior to a consolidation shall~~  
38    ~~be aggregated for the purposes of this article if: (1) a private~~  
39    ~~hospital consolidates with another private hospital, (2) the facilities~~  
40    ~~operate under a consolidated hospital license, (3) data for a period~~

1 prior to the consolidation is used for purposes of this article, and  
2 (4) neither hospital has had a change of ownership on or after the  
3 effective date of this article unless paragraph (2) of subdivision  
4 (d) has been satisfied by the new owner. Data of a facility that was  
5 a separately licensed hospital prior to the consolidation shall not  
6 be included in the data, including the days data source, for the  
7 purpose of determining the quality assurance fees due from the  
8 facility under the article for any time period during which such  
9 facility is closed. A facility shall be deemed to be closed for  
10 purposes of this subdivision on the first day of any period during  
11 which the facility has no general acute, psychiatric, or rehabilitation  
12 inpatients for at least 30 consecutive days. A facility that has been  
13 deemed to be closed under this subdivision shall no longer be  
14 deemed to be closed on the first subsequent day on which it has  
15 general acute, psychiatric, or rehabilitation inpatients.

16 (e) The quality assurance fees under this article shall not be due,  
17 for any period during which the hospital is closed. A hospital shall  
18 be deemed to be closed on the first day of any period during which  
19 the hospital has no general acute, psychiatric, or rehabilitation  
20 inpatients for at least 30 consecutive days. A hospital that has been  
21 deemed to be closed under this subdivision shall no longer be  
22 deemed to be closed on the first subsequent day on which it has  
23 general acute, psychiatric, or rehabilitation inpatients. Payments  
24 of the quality assurance fee under this article due from a hospital  
25 that is closed during any portion of a subject fiscal quarter shall  
26 be reduced by applying a fraction, expressed as a percentage, the  
27 numerator of which shall be the number of days during the  
28 applicable subject fiscal quarter that the hospital is closed during  
29 the subject fiscal year and the denominator of which shall be the  
30 number of days in the subject fiscal quarter.

31 (d) The procedure established by the director pursuant to  
32 subdivision (d) of Section 14169.58 shall apply to this article.

33 SEC. 9. This act is an urgency statute necessary for the  
34 immediate preservation of the public peace, health, or safety within  
35 the meaning of Article IV of the Constitution and shall go into  
36 immediate effect. The facts constituting the necessity are:

37 In order to make the necessary changes to increase Medi-Cal  
38 payments to hospitals and improve access at the earliest time, so  
39 as to allow this act to be operative as soon as approval from the  
40 federal Centers for Medicare and Medicaid Services is obtained

- 1 ~~by the State Department of Health Care Services, it is necessary~~
- 2 ~~that this act takes effect immediately.~~

O